Fourth Semi-Annual Report

September 15, 2006

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INTRODUCTION

This is the fourth semi-annual report of the Consultants Committee prepared pursuant to Section III F (5) of the Memorandum of Agreement Between the United States Department of Justice and the State of Arizona Concerning Adobe Mountain, Black Canyon, and Catalina Mountain Schools.

This report covers the time period commencing March 15, 2006 through September 15, 2006. The Committee will continue to issue a report every six months. The report is organized into discreet provisions and assigned Unique File Numbers (UFN's). Each consultant's sections can be identified by this numbering system.

This report acknowledges that the agency has now substantially complied with twelve provisions of the Memorandum of Agreement (MOA) for at least 18 months. Pursuant to Section III.H.5 of the Memorandum of agreement, the following sections of the MOA are terminated from the agreement and no longer subject to monitoring.

UFN Section	MOA Provision
3.2.2	III.A.2.(b)
3.2.3	III.A.2.(c)
3.2.6	III.A.2.(f)
3.3.2	III.A.3.(b)
4.4.1	III.B.4.(a)
4.4.7	III. B.4.(g)
5.4	III.C.4
5.9.1	III.C.9.(a)
6.4	III.D.4
7.3.1	III.E.3.(a)
7.3.2	III.E.3.(b)
7.3.4	III.E.3.(d)

The Consultants Committee continues to acknowledge the complete cooperation of the staff of the Arizona Department of Juvenile Corrections. Director Michael Branham has provided to the Committee complete access to all facilities, youth, staff, files and data.

At the conclusion of each site visit de-briefings continue to be held with Director Branham and his leadership team. The team has continued to be receptive to recommendations of the Consultants Committee and in many cases instituted remedial measures prior to the termination of the visit.

2. DEFINITIONS

Compliance with the Agreement requires that ADJC demonstrate substantial compliance for each of the substantive remedial measures at all three facilities. In this report, the Consultants Committee describes the steps taken by ADJC to implement the remedial measures and the extent to which ADJC has complied with the requirements of the Agreement. In assessing compliance, the Committee utilizes the following terms, which have been agreed upon by the parties:

Substantial Compliance: Substantial compliance with all components of the rated provision. Non-Compliance with mere technicalities, or temporary failure to comply during a period of otherwise sustained compliance will not constitute failure to maintain substantial compliance. At the same time, temporary compliance during a period of sustained non-compliance shall not constitute substantial compliance. A rating of substantial compliance shall not be made unless such rating is applicable to all three facilities.

Partial Compliance: Compliance has been achieved on most of the key components of the Agreement provision at all three facilities, but substantial work remains. A rating of partial compliance shall also be made where one or more facilities are in substantial compliance with a provision, but the other(s) are not in substantial compliance.

Non-Compliance: Non-compliance with most or all of the components of the Agreement requirements at all three facilities.

Not Reviewed: This rating is given if the Consultant's Committee due to time constraints in the initial reporting period could not adequately review it.

The Consultants Committee has collaborated in developing this report but individual consultants have taken primary responsibility for sections of the report:

Lindsay Hayes	Suicide Prevention
Russ Van Vleet	Juvenile Justice
Peter Leone	Special Education
Louis Kraus	Medical Care, Mental Health Care

3. SUICIDE PREVENTION

UFN 3.1 (Training), 3.1.1. The DOJ acknowledges that ADJC has designed and implemented a suicide-prevention training curriculum. ADJC shall continue to conduct suicide prevention training for youth contact staff. Within six months of the effective date of this Agreement, the State shall review and, to the extent necessary, revise its suicide prevention training curriculum, which shall include the following topics:

(1) (3.1.1.1) the ADJC suicide prevention policy as revised consistent with this Agreement;
(2) (3.1.1.2) why facility environments may contribute to suicidal behavior;
(3) (3.1.1.3) potential predisposing factors to suicide;
(4) (3.1.1.4) high risk suicide periods;
(5) (3.1.1.5) warning signs and symptoms of suicidal behavior;
(6) (3.1.1.6) case studies of recent suicides and serious suicide attempts;
(7) (3.1.1.7) mock demonstrations regarding the proper response to a suicide attempt; and
(8) (3.1.1.8) the proper use of emergency equipment.

Status: Substantial Compliance

Discussion: The 8-hour *Suicide Prevention Pre-Service Training Curriculum* and 4-hour *Suicide Prevention Refresher and Update* were both revised effective July 2006. In August, the Consultants Committee had an opportunity to attend an 8-hour pre-service suicide prevention training workshop. The workshop, presented by Thomas Seymour, PhD., was excellent and provided participants with a comprehensive overview of juvenile suicide prevention in general, as well as specific policy requirements within ADJC. As stated in previous reports, the Consultants Committee commends the ADJC for its efforts in developing and presenting a comprehensive suicide prevention training program.

Recommendation: Following attendance at the 8-hour suicide prevention training workshop, the Consultants Committee provided Vickie White, Staff Development and Training Administrator, will several recommendations regarding improvement/correction to the *Suicide Prevention Pre-Service Training Curriculum.* These recommendations were: 1) To eliminate confusion regarding "the youth's right to privacy about their past behavior and mental health disorders" and the staff member's responsibility to observe and report all suicidal behavior, add a note to the Instructor's Note in Slide 19 to indicate that the right to privacy does not extend to suicidal or other self-harming behavior; 2) Slide 21 deals with critical incident stress following the ADJC suicides and more appropriately should be moved to follow Slide 27; 3) on Slide 48, change "WB Page 3 " to "WB Page 5"; 4) the discussion of liability issues utilizing Slides 67 and 68 was weak and did not effectively communicate to participants the important factors of both individual and agency liability. This section should be revised with the assistance of Lou Goodman, Assistant Director-Legal Systems and/or by adapting PowerPoint slides recently forwarded to Vickie White by the Consultants Committee; and 5) the suicide of Billy in the ADJC occurred in the Challenge (not Freedom) Unit, see Case No. 1 of Participant Handouts.

Documentation: *Suicide Prevention Pre-Service Training Curriculum* (July 2006); attendance at

suicide prevention training workshop on August 10, 2006; discussion with Vickie White, Staff Development and Training Administrator.

UFN 3.1 (Training), 3.1.2. Within six months of the effective date of this Agreement, the State shall ensure that all existing and newly hired direct care, medical, and mental health staff, receive an initial eight-hour training on suicide prevention curriculum described in paragraph (1) above. Following completion of the initial training, the State shall ensure that two hours of refresher training on the curriculum are completed by all direct care, medical, and mental health staff each year.

Status: Substantial Compliance

Discussion: As of August 2006, 90% of all ADJC staff working at AMS, BCS, and CMS had completed either the original or revised 8-hour suicide prevention workshop, including 91% of direct care (including mental health) personnel, 97% of medical staff, and 84% of education staff. This high compliance rate, particularly for medical staff, is very impressive.

Completion rates were low for the 4-hour suicide prevention refresher workshop at all three facilities due to the revised workshop being inaugurated in June 2006. Vickie White, Staff Development and Training Administrator, estimates that all staff will be scheduled to complete the refresher workshop before the end of 2006.

Finally, as discussed in our previous report, the Consultants Committee observed that "contract" medical personnel had not received either the 8-hour or 4-hour suicide prevention workshop. Since that time, it would appear that most, if not all, contract nurses have received the 4-hour refresher suicide prevention training. On a related note, it also appeared to the Consultants Committee that private security personnel, hired to perform Level 1 supervision of suicidal youth housed in the Separation Units, were no longer being utilized at ADJC. If this function is ever reinstituted, all private security personnel working in the Separation Units should complete the 4-hour suicide prevention refresher training.

Recommendations: None

Documentation: Suicide Prevention Compliance Report of AMS, BCS and CMS (August 2006).

UFN 3.2 (Identification/Screening), 3.2.1. The DOJ acknowledges that the State has extensively revised its suicide prevention policies and procedures. Within six months of the effective date of this Agreement, the State shall revise its suicide prevention policy to reflect that any staff member who observes and/or identifies a youth as potentially suicidal shall immediately place the youth on suicide precautions and refer them to a qualified mental health professional for assessment.

Status: Substantial Compliance

Discussion: The Consultants Committee continues to find that ADJC staff consistently notify

either the unit manager or officer-in-charge when they observe and/or identify a potentially suicidal youth. The youth is then placed on suicide precautions and referred to QMHP staff.

On a related issue, the Consultants Committee had previously expressed concerns about the dramatic decrease in the number of CMS youth on suicide precautions. For example, the Consultants Committee reviewed each Daily Suicide Precautions Status List from AMS, BCS, and CMS for a 40-day period from December 1, 2005 through January 9, 2006 and found the following: AMS averaged approximately 2 (1.9) youth per day on suicide precautions, BCS averaged almost 6 (5.8) youth per day on suicide precautions, and CMS averaged 1 youth on suicide precautions every 8 days (.125). During this 40-day period, only 1 youth was on suicide precautions at CMS, and that was for five consecutive days. For the remaining 35 days, no youth was on suicide precautions at CMS.

We fully realized that there are several reasons for variations of suicide precautions at each facility, including the fact that AMS is larger and houses more mentally ill youth, and being a female facility, BCS houses youth who tend to engage in low lethality self-injurious behavior and are more demonstrative with their feelings. Yet the continued dramatic decrease in suicide precautions at CMS was striking.

The Consultants Committee has continued to monitor this issue and is pleased to report that there appeared to more youth consistently on suicide precautions during our most recent visit in August. For example, whereas CMS averaged 1 youth on suicide precautions every 8 days in January 2006, a review of all Daily Suicide Precautions Status Lists in July 2006 found that CMS averaged 1 youth on suicide precautions per day. As a result, the Consultants Committee believes that the identification process for suicide risk is working more accurately at CMS.

Recommendation: None

Documentation: Daily Suicide Precautions Status Lists from AMS, BCS, and CMS.

UFN 3.2 (Identification/Screening), 3.2.2. The State shall continue to ensure that any staff member who places a youth on suicide precaution shall document the initiation of the precautions level of observation, housing location, and conditions of the precautions.

Status: Substantial Compliance

Discussion: Pursuant to Section III.H.5 of the Memorandum of Agreement (MOA), this section of the MOA is terminated from the agreement and no longer subject to monitoring, based upon a finding of "substantial compliance" for at least 18 months.

UFN 3.2 (Identification/Screening), 3.2.3. The State shall continue to develop and implement policies and procedures to ensure that the documentation described in paragraph (b) above is provided to mental health staff and that in-person contact is made with mental health staff to alert them of the placement of a youth on suicide precaution.

Status: Substantial Compliance

Discussion: Pursuant to Section III.H.5 of the Memorandum of Agreement (MOA), this section of the MOA is terminated from the agreement and no longer subject to monitoring, based upon a finding of "substantial compliance" for at least 18 months.

UFN 3.2 (Identification/Screening), 3.2.4. The State shall continue to ensure that a formalized suicide risk assessment by a qualified mental health professional is performed within an appropriate time not to exceed 24 hours of the initiation of suicide precautions.

Status: Substantial Compliance

Discussion: The Consultants Committee continues to find good practices at all three facilities. ADJC currently utilizes several suicide risk assessment instruments at two points during a youth's confinement: 1) upon entry into the ADJC's Reception and Classification (RAC) units, and 2) upon observation and/or identification of suicidal behavior. Almost immediately upon entry into a RAC unit, several intake screening instruments are administered, including the Massachusetts Youth Screening Instrument-2 (MAYSI-2), the Initial Precautionary Risk Assessment (IPRA), Mental Status Exam Checklist, and CAPFA Domain 2 Behavioral Health-Mental section. The MAYSI-2 is administered to the youth by a non-QMHP staff, but scored by QMHP staff, whereas both the Initial Precautionary Risk Assessment, Mental Status Exam Checklist, and CAPFA Domain 2 Behavioral Health-Mental are administered to the youth by QMHP staff. In addition, any time a youth is either observed and/or identified as being potentially suicidal, the youth is assessed by QMHP staff utilizing a Crisis Intervention Assessment (CIA) form. The CIA form contains the youth's name, "K" number, housing unit, date and time of assessment, QMHP staff performing the assessment, self-reported behavior, findings/observations, mental status exam, assessment, recommended suicide observation level, and plan. The Consultants Committee found that the CIA form is always administered well within 24 hours of the youth being initially identified and/or observed displaying potentially suicidal behavior.

Recommendation: None

Documentation: ADJC Policy 4250.01, Policy 4203.01; Massachusetts Youth Screening Instrument-2 (MAYSI-2); the Initial Precautionary Risk Assessment; Mental Status Exam Checklist; and CAPFA Domain 2 Behavioral Health-Mental section; sample case file reviews; interviews with QMHP Staff

UFN 3.2 (Identification/Screening), 3.2.5. The State shall continue to ensure that mental health staff thoroughly review a youth's clinical and master files for documentation of any prior suicidal behavior.

Status: Substantial Compliance

Discussion: The Consultants Committee has seen further improvement in this area. With a fully integrated health care file (see 3.2.8 below for further discussion), QMHP are in a better position to review the youth's mental health file. In addition, the March 2006 60-Day Suicide Prevention Audit found that QMHP were more consistently reviewing the Red Folders (containing Suicide

Prevention Time Sheets and Crisis Intervention Assessments) of youth on suicide precautions.

However, the Consultants Committee was very troubled by a programming error in the ADJC's YouthBase management information system which blocked QMHP staff from accessing and reviewing a fellow clinician's progress notes (i.e., Contact Detail Report) if it was marked "confidential." A clinician would mark a Contact Detail Report as confidential if they did not want non-QMHP staff to access the note. The problem, however, was that a Contact Detail Report marked confidential was also not available to QMHP who needed the review the note. The Consultants Committee raised this issue during a debriefing session in March 2006 and, as of another visit in August 2006, the problem had still not been corrected. It was again raised during the August debriefing.

On August 17, the Consultants Committee was informed by Patti Cordova, Division Director, Communications/Legislation that the problem had been corrected by reprogramming the YouthBase system through insertion of the names of all QMHP staff on an authorized list to view confidential screens. By inserting these employee names in the program, QMHP will now have access to all Contact Detail Reports by fellow clinicians that are marked confidential.

Although this issue is hopefully resolved, the Consultants Committee found it disconcerting that it was we, not QMHP staff, that brought this historical problem forward for correction, suggesting that QMHP staff were not concerned and/or interested enough to review Contact Detail Reports by colleagues marked as confidential. In fact, one QMHP supervisor informed the Committee that they were curious why they could not always access Contact Detail Reports. Another clinician stated they never noticed the "confidential" box on the Youthbase program. Although it should also be stated that not all Contact Detail Reports are marked confidential and QMHP staff can still access hard copies of the Reports in the youth's mental health file located in the medical unit, this issue does raise the continued concern regarding the consistency by which QMHP staff thoroughly review a youth's clinical file.

In conclusion, although the Consultants Committee believes that continued steady progress in this area deserves a rating of substantial compliance for this section, we will closely monitor this issue in the future.

Recommendation: None

Documentation: 4th 60-Day Suicide Prevention Audit (March 2006); interviews with QMHP staff; interview with Patti Cordova, Division Director, Communications/ Legislation.

UFN 3.2 (Identification/Screening), 3.2.6. The State shall continue to ensure that newly arrived residents are placed under close observation until they can be assessed by mental health staff.

Status: Substantial Compliance

Discussion: Pursuant to Section III.H.5 of the Memorandum of Agreement (MOA), this

section of the MOA is terminated from the agreement and no longer subject to monitoring, based upon a finding of "substantial compliance" for at least 18 months.

UFN 3.2 (Identification/Screening), 3.2.7. The State shall develop and implement policies and procedures to expeditiously obtain from the juvenile divisions of all Superior Courts in the state, as well as all county juvenile detention facilities and/or placement settings from which the youth is committed, all pertinent records with the youth upon commitment to ADJC within one week of the youth's arrival.

Status: Substantial Compliance

Discussion: ADJC entered into a Memorandum of Agreement (MOU) with the Administrative Office of the Courts concerning the timely transfer of pertinent information on youth committed to the agency from local juvenile courts throughout the state. Effective April 2005, the agreement requires that juvenile courts submit these pertinent records within seven (7) days of the youth's arrival to ADJC. A *Checklist for Juvenile Commitment to ADJC* was developed, and includes, but is not limited to, the requirement for juvenile courts to forward "incident reports generated during current detention period," "documentation of any suicidal behavior or ideation" and "psychological and psychiatric reports, including mental health treatment summaries." Although local court systems are allowed up to 7 days to submit this information, the records are ideally transferred with the youth upon their arrival at the ADJC's RAC unit.

There continues to be recent progress in this area. For example, the Consultants Committee was informed that Patti Cordova, Division Director, Communications/Legislation and Kellie Warren, Program Administrator, Medical and Behavior Health Division, met in June 2006 with representatives of the Administrative Office of the Courts to provide further instruction on the revised *Checklist for Juvenile Commitment to ADJC.* The revised form now better highlights (in bold print) a previous requirement for "Documentation of any suicidal behavior, ideation or self-injurious behavior, if applicable."

Despite ADJC's efforts, the Consultants Committee continues to find inconsistency regarding the types of documents forwarded from county juvenile detention centers for youth entering ADJC custody. In some cases, pertinent documents from a youth's recent county detention facility history and prior psychological and/or psychiatric evaluations were forwarded. Some counties had even forwarded discharge summaries. In other cases, however, there were no documents forwarded from a youth's recent county detention facility history and prior psychological and/or psychiatric evaluations. Three more recent examples exemplify this inconsistency.

Youth A.S. entered BCS on March 16, 2006 from Pinal County. The county records were extensive and included a pre-dispositional report documenting the youth history of self-harm and suicidal ideation in detention; incidents reports regarding two incidents of self-harm in detention; recent mental health records from a residential treatment center; and a psychiatrist's assessment while the youth was detained.

Youth L.T. entered BCS on July 19, 2006 from Pima County. The county records were also extensive and included a "Detention Behavioral Information Report" (see below), as well as both

a psychological and psychiatric evaluation.

On the other hand, Youth J.N. entered CMS on July 20, 2006 from Pima County. A psychological evaluation and Checklist for Juvenile Commitment to ADJC form were included in the county records. The Checklist noted that the "Incident Reports Generated Current Detention Records" were attached. However, following a thorough review of the youth's field, medical, and mental health files, these incident reports could not be found. In addition, a "Detention Behavioral Information Report" which had been completed by Pima County one day earlier on Youth L.T. (see above), was not completed on this youth.

In conclusion, although much more consistency needs to be shown, ADJC's continued commitment and progress in this area have resulted in a rating of substantial compliance.

Recommendations: The Consultants Committee found one form, apparently created by the Pima County Juvenile Detention Department, that was particularly helpful. The form, entitled "Detention Behavioral Information Report" contained the following information: "number of suicide, housing, disciplinary and security risk statuses; summary of suicidal behavior; summary of detainee's behavior, attitudes, and willingness to follow staff directions; summary of possible contributing factors to detainee's behavior and attitudes; and summary of detainee behavior in last 24 hours." Unfortunately, the Committee found that the form was only completed on one Pima County youth (L.T.) in the reviewed files.

The Committee would strongly recommend that ADJC encourage Pima County, as well as all Arizona counties, to utilize the "Detention Behavioral Information Report" or similar form to communicate the medical, mental health, and/or suicide risk management needs of youth entering ADJC custody.

Documentation: Memorandum of Agreement Between the Administrative Office of the Courts and the Arizona Department of Juvenile Corrections; revised Checklist for Juvenile Commitment to ADJC; sample case file reviews; interviews with Patti Cordova, Division Director, Communications/Legislation, Kellie Warren, Program Administrator, Medical and Behavior Health Division, and Megan McGlynn, Quality Assurance Administrator.

UFN 3.2 (Identification/Screening), 3.2.8. The State shall develop and implement policies and procedures to ensure that ADJC creates an integrated medical and mental health record system for each youth. The State shall promulgate a policy requiring that all ADJC mental health staff shall be required to utilize progress notes to document each interaction and/or assessment of suicidal youth.

Status: Substantial Compliance

Discussion: ADJC developed a Maintenance of the Mental Health Records policy (1120) that specifies the documents (including the IPRA and CIA) to be included in each youth's mental health file. Due to liability concerns among some ADJC officials, the mental health and medical records are not fully integrated. The mental health records are now placed in a separate file

cabinet next to the health care files in each facility's medical unit. In addition, outside mental health records, most of which are confidential, have been removed from the field files and are now relocated into newly created mental health files for each youth. Finally, the Consultants Committee continues to observe improvement in completion of progress notes (i.e., CIA forms) by QMHP staff. The 4th 60-Day Suicide Prevention Audit (March 2006) also found improvement in this area. Although a handful of mental health staff still are not consistently documenting each required assessment of youth, the vast majority of QMHP are now in compliance with this requirement.

Recommendation: None

Documentation: ADJC Policy 1120; inspection of medical units and mental health files; 4th 60-Day Suicide Prevention Audit (March 2006).

UFN 3.2 (Identification/Screening), 3.2.9. The State shall continue to develop, implement, and comply with policies and procedures for communicating the management needs of suicidal youth among direct care, medical, and mental health personnel.

Status: Substantial Compliance

Discussion: Clinical team meetings occur on a regular weekly basis at each facility, and these meetings consistently include psychology associates, psychologists, and psychiatrists. The management and treatment plan needs of each youth on suicide precautions are required to be discussed during these weekly meetings. In our March 2006 report, we were also informed that YPO IIIs have been invited to attend these sessions. Finally, a hard copy of the Daily Suicide Prevention Status List is consistently generated and kept in the Medical Unit in each facility.

It should be noted, however, that the Consultants Committee had an opportunity to observe a recent clinical team meeting at AMS in August 2006 and was very disappointed in its content. There were only five QMHP staff in attendance (the clinical supervisor and four psychology associates). The RAC clinicians were <u>not</u> at the meeting and had not been in attendance for several months. This is particularly disconcerting given that RAC clinicians are the first QMHP staff to assess youth and often place them on suicide precautions. They are certainly the most knowledgeable about a youth's background and their absence from the clinical team meeting was pronounced. In addition, the YPO IIIs have been invited to, but have rarely attended, a clinical team meeting at AMS. Further, the meeting was far more administrative than clinical, with staff spending more time discussing future training opportunities off-site than the treatment needs of youth. There was only cursory discussion of the four youth currently on suicide precautions.

Most importantly, there was <u>no</u> discussion regarding any of the youth that were on standard supervision (Level 4) and being dropped from the Daily Suicide Prevention Status List. This omission was the most disturbing of all. The sole purpose of keeping a youth (who has been downgraded to standard supervision) on the Daily Suicide Prevention Status List until the next clinical team meeting is for the clinical team to discuss the youth's treatment needs and ensure there are no outstanding issues that need to be addressed. As discussed in more detail below in 3.4.2., there was also little discussion about treatment planning for any youth.

In sum, the AMS clinical team meeting was disjointed, poorly attended, and lacked a clinical focus.

Finally, on a related note, the 4th 60-Day Suicide Prevention Audit (March 2006) found that all three facilities were doing an inadequate job of consistently utilizing Transfer/Discharge Summary forms when youth are transferred among facilities. These forms are critical to effective communication and the safe management of suicidal youth.

In conclusion, although the ADJC is technically in substantial compliance with this section and the Consultants Committee's suicide prevention consultant was only able to attend one clinical team meeting during this reporting period, the clinical team meeting at AMS on August 9 was deeply troubling. This issue will be closely monitored by the Consultants Committee in the up-coming months.

Recommendations: First, upon assignment of a permanent clinical supervisor at AMS, ADJC needs to initiate quality clinical team meetings that are attended by most, if not all, QMHP staff, as well as YPO IIIs. Second, it is strongly recommended that ADJC develop a corrective action plan to ensure a high rate of completion of Transfer/Discharge Summary forms.

Documentation: ADJC Policy 4250.01; Daily Suicide Prevention Status Lists; interviews with QMHP staff; observation of clinical team meeting at AMS on August 9.

UFN 3.3 (Safe Housing of Suicidal Youth), 3.3.1. The DOJ acknowledges that the State has taken significant steps to remedy physical plant hazards to suicidal youth. The State shall continue its remedial plans to ensure that all youth placed on suicide precaution are housed in suicide-resistant rooms (i.e., rooms without protrusions that would enable youth to hang themselves).

Status: Substantial Compliance

Discussion: As stated in our previous reports, ADJC has expended significant resources to ensure that rooms housing suicidal youth are as "suicide-resistant" as possible. As one QMHP previously told the Consultants Committee, the incidents of serious suicide attempts have been dramatically reduced because the individual rooms are physically much safer.

The Consultants Committee performed a thorough physical plant review of all housing units in each of the facilities during the past several months and found that S-vents have been installed in all rooms. Although a youth can still attempt suicide if given the opportunity, all the resident rooms are now as "suicide-resistant" as possible.

Finally, the Consultants Committee would note a previous troubling practice of allowing youth to cover their heads with blankets thus obstructing full visibility, as well as staff not conducting documented 15-minute rounds in the Separation Units, appears to be corrected. We found that youth are no longer allowed to cover their heads and documented rounds at 15-minute intervals appear to be occurring on all three shifts in the Separation Units of all three facilities.

Recommendation: None
Documentation: ADJC Policy 4250.01; tour of select housing units, including Separation Units; review of Separation Unit logs; interviews with YCO staff.
UFN 3.3 (Safe Housing of Suicidal Youth), 3.3.2. The State now requires that all direct care staff carry packs on their person containing extraction tools and CPR microshields. The State shall continue to ensure that direct care staff has immediate access to appropriate equipment to intervene in the event of an attempted suicide.
Status: Substantial Compliance
Discussion: Pursuant to Section III.H.5 of the Memorandum of Agreement (MOA), this section of the MOA is terminated from the agreement and no longer subject to monitoring, based upon a finding of "substantial compliance" for at least 18 months.
UFN 3.4 (Supervision), 3.4.1. The State shall develop and implement a "step-down" level of observation whereby youth on suicide precaution are released gradually from more restrictive levels of supervision to less restrictive levels for an appropriate period of time prior to their discharge from suicide precaution.
Status: Substantial Compliance
Discussion: Overall, the Consultants Committee continues to find that current practices are consistent with this policy at each facility.
Recommendation: None
Documentation: ADJC Policy 4250.01; Daily Suicide Prevention Status Lists.
UFN 3.4 (Supervision), 3.4.2. The State shall ensure that all youth discharged from suicide precaution continue to receive mental health treatment in accordance with a treatment plan developed by a qualified mental health professional.
Status: Partial Compliance
Discussion: Section 5 of ADJC's suicide prevention policy (4250.01) requires QMHP staff to "Note treatment follow-up and recommendations on the CIA form whenever juvenile is downgraded or is removed from precautionary status; Ensure treatment follow-up and recommendations are viewed and discussed at each weekly clinical meeting; and Ensure that the juvenile's case plan includes goals and objectives pertaining to suicide prevention and/or self-injurious behavior." Current practice is for suicidal youth to be downgraded from Level 1 to Level 2 to Level 3, and then to Level 4 prior to being discharged from suicide precautions. In addition, Level 4 youth remain on the Daily Suicide Prevention Status List until their case is discussed at the weekly

clinical team meetings.

The Committee of Consultants acknowledged that the Department monitors and supervises youth who have been discharged from suicide precautions. However, as discussed in detail in our March 2006 report, despite the requirement for QMHP staff to document a treatment plan and appropriate follow-up services on both the youth's CIA and Continuous Case Plan, the Consultants Committee found that such documentation was still either not occurring or treatment planning was inadequate. There were several reviewed cases that illustrate this problem.

Youth T.S., who had a significant history of suicide attempts by hanging in detention, was placed on Level 3 suicide precautions in CMS on February 19, 2006 for self-injurious behavior. He was seen daily by QMHP staff and remained on suicide precautions until March 1. The treatment recommendations on his CIA form of March 1 stated the following: "Youth encouraged to actively program, Youth was discouraged from self-harm, and Youth was encouraged to demonstrate appropriate behavior until release." He was also placed on CMS's "High Profile Risk" List and was to be followed weekly by his clinician. There were four subsequent Contact Detail Reports written during the next two weeks concerning group participation (1), his the relationship with his mother (2), and as a response to his placement in the Separation Unit (3). None of the Contact Detail Reports mentioned a treatment plan for self-harming behavior. Finally, a Continuous Care Plan (CCP), written on March 3, failed to include self-harm or suicide as a problem area.

Youth B.R. was sent to the Arizona State Hospital from CMS for approximately four weeks for treatment of obsessive-compulsive disorder, sexual behavior, and refusal to program in the facility. Although the youth did not have a history of self-harm and was never suicidal during his CMS confinement, upon return to CMS on July 10, he was appropriately placed on Level 1 supervision as per ADJC policy for all youth returned from the state hospital. Youth B.R. was appropriately downgraded daily from Level 3 to Level 4 and released from standard supervision on July 13. A CCP was completed on July 18 with "Suicidal Ideation/Attempt" listed as a secondary problem area that required a treatment plan. The long-term goals were to "stabilize the suicidal crisis and place in an appropriate level of care to address the suicidal crisis." The short-term goals were to "verbalize a promise (as part of a suicide prevention contract) to contact the therapist or some other emergency helpline if a serious urge toward self-harm arise." There are several problems with this CCP. First, ADJC does not have an "emergency helpline." More importantly, Youth B.R. was <u>not</u> suicidal and had <u>never</u> been suicidal. A thorough review of the youth's mental health file failed to show any hint of suicidal behavior, past or present, and insertion of suicide in his CCP was completely without merit.

Youth L.A. was placed on suicide precautions in BCS for self-injurious behavior. On February 28, 2006, the youth was placed on standard supervision with the CIA outlining the following treatment plan: "Monitor youth on standard level, notify QMHP if youth's mood or behavior decompensates, and encourage you to speak with staff and/or peers when feeling depressed and/or angry." (The Committee would note that this boilerplate language was found in several treatment plans of BCS youth.) There were two Contact Detail Reports in the file, dated March 2 and 8. A CCP, dated February 21, was not updated to include a treatment plan for this youth's self-harming behavior.

The committee also reviewed several mental health files on AMS youth. The same problems regarding inadequate treatment planning and follow-up care were found.

Finally, as previously stated in our March 2006 report, the acting Mental Health Supervisor at CMS instituted a local practice of creating a "CMS High Profile Youth" list. Youth on the list are required to be seen at least weekly by QMHP staff, as well as discussed during the weekly clinical team meetings. Youth remain on the list until they are "incident-free" for at least one week. In addition, all youth on psychotropic medication in CMS are seen by QMHP staff on a weekly basis. We previously recommended that ADJC should decide whether the local protocols at CMS regarding provision of weekly follow-up services for "high risk" youth and those receiving psychotropic medication should be revised and formalized as an agency policy, and then instituted within the other facilities. The Committee has since been informed that the issue is still "under advisement." The Committee also previously recommended in March 2006 that ADJC develop a corrective action plan to ensure compliance with 3.4.2. It is apparent to the Committee that the corrective actions taken have not been effective to date.

Recommendations: The Committee's March 2006 recommendations are repeated here again as follows. First, it is strongly recommended that ADJC develop a corrective action plan to ensure compliance with 3.4.2. Second, ADJC should decide whether the recent local protocols at CMS regarding provision of weekly follow-up services for "high risk" youth and those receiving psychotropic medication should be revised and formalized as an agency policy, and then instituted within the other facilities. The Consultant Committee does not feel it appropriate to have local practices that are not officially sanctioned by central office and independently operating throughout the agency.

Documentation: ADJC Policy 4250.01; sample case file reviews; interviews with QMHP staff.

UFN 3.5 (Intervention), 3.5.1. The State has revised ADJC's suicide prevention policy to specify the proper role of staff in responding to a suicide attempt by youth and shall continue to ensure that staff are trained in appropriate response techniques and the use of emergency equipment on an annual basis.

Status: Substantial Compliance

Discussion: As of August 2006, 81% of all ADJC staff working at AMS, BCS, and CMS had completed the CPR workshop, including 79% of direct care (including mental health) personnel, 86% of medical staff, and 88% of education staff.

As of August 2006, only 31% of all ADJC staff working at AMS, BCS, and CMS had completed the 1-hour Extraction Knife Training workshop (see Section 3.1.1.8 which requires training on "the proper use of emergency equipment"), including 19% of direct care (including mental health) personnel, 77% of medical staff, and 77% of education staff. These completion rates are very low because a revised 4-hour suicide prevention refresher workshop at all three facilities was inaugurated in June 2006. Vickie White, Staff Development and Training Administrator, estimates that all staff will be scheduled to complete the refresher workshop before the end of

2006. (The 1-hour Extraction Knife Training workshop is included within the suicide prevention refresher workshop.)

Recommendation: None

Documentation: ADJC Policy 4250.01; Suicide Prevention Compliance Report of AMS, BCS and CMS (August 2006); *Suicide Prevention Refresher and Update* (July 2006); discussion with Vickie White, Staff Development and Training Administrator.

UFN 3.6 (Mortality Review), 3.6.1. The State shall continue to ensure that all completed suicides and serious suicide attempts are reviewed by the Internal Review Committee for policy and training implications.

Status: Substantial Compliance

Discussion: As discussed in previous reports, there are two layers of ADJC review following a completed or serious suicide attempt -- critical incident debriefing (1190.02) and internal review committee (4250.03).

The Critical Incident Debriefing is a multidisciplinary review at the facility level and involves: "1) a review of the circumstances surrounding the incident; 2) the effect of the incident on involved employees and juveniles; 3) the cause or potential causes of the incident; 4) identification of known or potential deficiencies in operational procedures and/or practices including circumstances leading up to the incident, response to the incident, and follow-up and notification after the incident; 5) need for immediate corrective action and steps taken; 6) specific employee training issues; 7) review of other options that were possibly available in resolving the incident; 8) identification of appropriate and/or extraordinary responses by employees or juveniles; and 9) assignments and delegation of report writing, including incident reports, and investigations, interviews, etc."

The Internal Review Committee is a multidisciplinary review at the central office level that is chaired by the Quality Assurance Administrator and includes critical review of: "1) the circumstances surrounding the incident; 2) the facility or community procedures relevant to the incident; 3) any Incident Debriefing Reports; 4) all relevant training received by involved employees; 5) all pertinent supervision and treatment plan reports; 6) all pertinent medical and mental health services/reports involving the victim; 7) pertinent family dynamics; and 8) recommendations for possible improvements in employee training, operational procedures, physical plant, and program services.

The Consultants Committee examined six Critical Incident Debriefing reviews and four accompanying Internal Review Committee reviews conducted during February and July 2006. The reviews involved the following incidents and youth:

Youth B.B. at BCS on February 17
Youth T.S. at CMS on February 18
Youth C.A. at BCS on May 28

Youth Z.A. at EPS on June 11
Youth D.N. at EPS on June 13
Youth E.G. at BCS on June 13

Overall, both review processes were adequate and documented the positive and negative issues related to each incident. There was, however, a pattern in both the CID and IRC reviews to focus solely upon the emergency response to the suicide attempt and not on systemic review of the youth's background and treatment between admission to the facility and the incident. For example, although ADJC policy requires that the Internal Review Committee "review all pertinent supervision and treatment plan reports" and "review all pertinent medical and mental health services involving the victim," there was no indication in any of the IRC reviews that these documents were reviewed, or even if any of these youth were on suicide precautions at the time of the incidents.

In addition, the Committee noticed the following omissions in the CID and IRC reviews:

1) In Youth B.B.'s case, medical staff did not attend the CID and education staff did not attend either the CID or IRC;

2) In Youth T.S.'s case, medical and education staff did not attend the CID, there was no 21-review completed by the facility superintendent, and there was no IRC review completed;

3) In Youth C.A.'s case, medical and education staff did not attend the CID, there was no 21-review completed by the facility superintendent, and there was no IRC review completed;

4) In Youth Z.A.'s case, medical and education staff did not attend the CID;

5) In Youth D.N.'s case, medical and education staff did not attend the CID and education did not attend the IRC; and

6) In Youth E.G.'s case, medical and education staff did not attend either the CID or IRC, and there was no 21-review completed by the facility superintendent.

In conclusion, although a rating of substantial compliance is given to this section because ADJC is now conducting CIDs and IRCs on almost a regular basis, more progress is needed in the quality of, and attendance at, the reviews.

Finally, on a related issue, the Consultants Committee is concerned about the uncertain future of the 60-Day Suicide Prevention Audits. The audits were stopped in March 2006 following the departure of an ADJC central office staff who was a subject matter expert in this area. Although the 60-day audits are not required in the CRIPA Agreement, nor have they been by the Consultants Committee, the process has been extremely beneficial to ADJC and the Committee. It also symbolizes to agency staff how important
proper documentation is to suicide prevention. In addition, given the ADJC's struggles with treatment planning (see 3.4.2), there is even a greater need that these 60-Day audits be re-established.

The annual facility audits conducted by the Quality Assurance Division do not address suicide prevention, nor do team members possess the expertise to thoroughly and efficiently review medical/mental health
case files to audit suicide prevention practices. (In addition, although the annual facility audits include interviews with youth regarding the "quality of health care services," the interviews do not address the "quality of mental health services.") Given the fact that the CRIPA Agreement is entering its third year, a solid quality assurance process needs to be in place for suicide prevention. Without a 60-Day Suicide Prevention Audit process, the Consultants Committee would have serious concerns about future practices and quality assurance efforts in this area.

Recommendations: First, as required by ADJC policy, both medical and education staff must be represented at the Critical Incident Debriefing and Incident Review Committee reviews on a regular basis. Second, as required by ADJC policy, the IRC reviews should focus more on a systemic review of the youth's background and treatment between admission to the facility and the incident (i.e., "review all pertinent supervision and treatment plan reports" and "review all pertinent medical and mental health services involving the victim). Third, it is strongly recommended that the 60-Day Suicide Prevention Audit process be re-established. Fourth, it is strongly recommended that "quality of mental health services" interviews be added to the annual facility audits of the Quality Assurance Division.

Documentation: ADJC Policy 4250, Policy 4250.03, Policy 1190.02; reviews of six Critical Incident Debriefings and four Internal Review Committee summaries; *Quality Assurance Audit: Black Canyon School* (2006); discussion with Megan McGlynn, Quality Assurance Administrator.

4. JUVENILE JUSTICE

4.1 Grievance System

UFN 4.1.1 Upon the effective date of this Agreement, the State shall provide youths with an effective, reliable process to raise grievances without exposing them to retribution from staff. The State shall:

Status: Substantial Compliance

Discussion: The recommendation from the previous report asked that youth going through the RAC process sign forms indicating that they had received the handbook. BCS does have documentation in youth files verifying the receipt of the handbook by each youth. The handbook is given to the students at orientation. Youth interviews at CMS and AMS verified they were aware of the grievance process, had confidence and in many cases had used it.

Recommendation: None.

Documentation: Meeting with Margie Lucas in RAC unit at BCS during site visit June 5, 2006. Review of forms: RAC YPO III Completion Tracking; Venture RAC New Commitment Orientation Check List; Reception, Assessment and Classification; Cottage roster that documents each youth, date of arrival, completion of RAC, estimated release date, DOB, Parole Officer, Staffing dates, status, and clinical specialist; Interviews with youth at AMS and CMS during June site visit.

UFN 4.1.1.1 Ensure that at the time of orientation, newly arrived youths receive a clear explanation of the grievance process, and that youths' understanding of the process is at least verbally verified.

Status: Substantial Compliance

Discussion: Youth at BCS are oriented personally on grievances by the Youth Ombudsman. In addition, the staff orient the youth to the process as part of the orientation.
Met with youth at CMS and AMS. They all verified that they received grievance training as part of the orientation process.

Recommendation: (**Required**) Provide documents to the consultant verifying training at RAC on grievances and distribution of handbook.

Documentation: Verified that youth are trained at the RAC unit at BCS on the grievance process during site visit of June 5, 2006. Verified that youth receive the training by personal interviews with the youth at the CMS site visit of June 6 and the AMS site visit of June 7, 2006.

UFN 4.1.1.2 Ensure that, without any staff involvement, youths can easily obtain grievance forms and submit grievances directly.

Status: Substantial Compliance

Discussion: Interviews were held with youth in the 3 facilities during the June 5-8 site visit. Without exception youth indicated that grievance forms are available through the grievance coordinator (youth) in each cottage.

When the settlement agreement was developed and the monitoring began there were over 300 grievances that were unaccounted for. The tracking of those forms has continued during the last two years and currently there are only 13 grievances that are not through the process in the allotted time. These are all due to staff being on vacation and two of those are 5 days late and 11 are one day late. In addition the grievance summary report for April shows that 50 forms were distributed, 40 cancelled, (youth decide not to proceed with the grievance) 10 received, 8 timely or early, and 2 late.

Recommendation: None at this time.

Documentation: Meeting with Lou Goodman and Sheila Press during the July site visit. Review of memos provided by Sheila Press documenting the grievance review and

accountability process**.** Grievance Summary Report for 4/01/06 to 4/30/06. .
UFN 4.1.1.3 Ensure that there are no formal or informal preconditions to the completion and submission of a grievance.
Status: Substantial Compliance
Discussion: One issue remains with the grievance procedure and that is the proper resolution of them and the provision of the resolution in writing to the youth. Sheila Press has been reviewing resolutions. During this reporting period several resolutions were questioned and the process for resolving those resolutions were reviewed. The May review contained one resolution at AMS and one at BCS. This process is in place and has been verified through interviews with youth and documentation from Sheila Press.
Recommendation: (Required) Continue the tracking of the grievance forms and resolutions, provide to consultants for review.
Documentation: Review of grievance resolutions for May 2006.
UFN 4.1.1.4 Ensure that grievances are examined and investigated by persons other than staff and the direct supervisors of those staff, who supervise the youth making the grievance. This provision shall not be interpreted to exclude the possible use of mediation in accordance with ADJC policy and procedure to resolve grievances.
Status: Substantial Compliance
Discussion: Grievances are investigated by staff other than those supervising youth. This process has now been verified during the last two reporting periods. In addition the QA process includes a review of grievances involving staff misconduct which provides another check and balance to insure that youth can file grievances regarding staff conduct.
Recommendation: Provide consultants with audits for review during the remainder of the monitoring process.
Documentation: Discussion at de-briefing during June 2006 site visit.
UFN 4.1.1.5 Ensure that a youth who files a grievance is informed in writing of the results of the grievance process.
Status: Substantial Compliance
Discussion: Sheila Press reviews each grievance and each resolution. She returns resolutions to staff if changes are needed. Youth are informed in writing.
Recommendation: (**Required**): The Consultants Committee recommends that resolutions be summarized on a monthly basis and forwarded for review in order to facilitate monitoring.

Documentation: Meeting with Sheila Press during the July site visit. Review of memos from Sheila to staff regarding the June 2006 grievances and memos from Art Bell and Mark LaBouchardiere to Sheila Press regarding the June 2006 grievances**.**

4.2 Protection from Harm

This section is divided into two. 4.2.1 The reporting and investigation of allegations of abuse and 4.2.1A Protection from Harm.

UFN 4.2.1 The reporting and investigation of allegations of abuse. The DOJ acknowledges that the State has made significant efforts to improve the policies, procedures, and practices for the reporting and investigation of allegations of abuse of a youth made by any person, including youth. Effective immediately upon the effective date of this Agreement, the State shall continue to make all reasonable efforts to ensure that all youth are protected from harm and that all allegations of abuse, including but not limited to physical and sexual abuse, are investigated in a timely and thorough manner by ADJC's Investigations and Inspections Unit, or other appropriately trained investigative personnel, as designated by the ADJC Director.

Status: Substantial Compliance

Discussion: Reporting and investigations of allegations of abuse: This Division continues its work. The 4th quarter statistics are added.

Inspections and Investigations Unit

(1) In the 1st Semi-Annual Report a summary of the I&I Unit was presented to demonstrate responses to allegations of abuse. The 2nd report updated that activity and that process is followed here allowing for a compilation of activity by I&I and a comparison of the I&I activity over the first 18 months of the agreement.

The first quarter had 810 (796 was the figure provided in the earlier report).

The second quarter had 962. (These reports can be electronically retrieved for comparison purposes).

Third Quarter:
A total of 876 incident reports were reviewed by the Investigations Division the Third Quarter of 2005 (the report is dated October 6, 2005).

Fourth Quarter:
A total of 707 incident reports were reviewed by the Investigations Divisions.

2006
First Quarter:
A total of 715 total incidents were reviewed.

Second Quarter:

A total of 623 incidents were reviewed.

I & I Division Quarter Report 2006				
	Quarters			
	1st	2nd	3rd	4th
Total Incidents Reviewed	**715**	**623**		
Assigned to Criminal Investigator	104	101		
Submitted to County Attorney	48	29		
Cleared by Arrest	5	5		
Unfounded	6	9		
Cleared Exceptional	52	47		
Information Only	13	16		
Assigned to Professional Standards Unit	**39**	**52**		
Sustained	19	30		
Partially Sustained	0	0		
Not Sustained	13	18		
Unfounded	5	17		
Inspections				
Random Inspections	36	13		
Audits	1	2		
Follow-Up Audits	0	0		
Background Investigations				
Opened	354	127		
Failed Background	58	34		
Cleared Backgrounds	269	245		
Stopped Per Hiring Authority	29	9		

In addition the I&I reports that the trend of cases that are assigned to criminal investigators show a downward trend-indicating that serious criminal activity appears to be decreasing in the facilities. Also, that PSU cases show a slight downward trend, yet those that are sustained (employees violated policy) show a significant increase. Information only reports show a significant increase. This is explained by the application of "Reporting Child Abuse" policy, which requires Agency staff to report child abuse and molestations. A majority of these reports are for crimes that occurred outside of ADJC jurisdiction, yet Investigators conduct preliminary investigations and then report it to the local Law Enforcement jurisdiction and if need be to Child Protective Services.

The next year it will be important to continue to track this activity to see if, in fact, the downward trend holds.

Recommendation: (**Required**) This recommendation is continued. The Consultant's Committee recommends that the integration of the QA into the I&I continue as scheduled and that the auditing of I&I activities be identified and included in the next reporting period.

Documentation: Discussion with John Dempsey, Administrator of I&I and Megan McGlynn, Director of the Quality Assurance Office during site visits in June, 2006 review of February 1, 2006 memo from John Dempsey to Michael Branham providing the I&I Division Annual Report 2005. Electronic mail from John Dempsey of August 28, 2006 providing I&I annual statistics

and trends.

4.2.1 A Protection from Harm

Status: Partial Compliance

Discussion: During each reporting period youth have been interviewed. During this last site visit, June 5-8 2006 youth were interviewed in each of the facilities. All youth reported feeling safe within their cottages. As in previous reports there is still indication of youth fighting. All youth indicated that they did not view this as threatening to their personal safety but as a reality when confined in a corrections facility. All expressed confidence that while there were youth on youth assaults staff did not allow them to escalate to the point of youth being in danger or being seriously hurt.

	9/04 – 2/05 CRIPA Rpt #1		3/05 to 8/05 CRIPA Rpt #2		9/05 to 2/06 CRIPA Rpt #3		3/06 to 8/06 CRIPA Rpt #4	
CRIPA Summary (AMS, RAC, BCS & CMS)	**Total**	**Rate**	**Total**	**Rate**	**Total**	**Rate**	**Total**	**Rate**
Total # calls responded to by Security	2933	5.08	5726	6.68	5977	7.21	5386	6.49
Total # of Youth Injured (all sources)	1099	1.26	1334	1.56	1126	1.36	832	1.00
Total # Youth Assaulted by Youth	192	0.22	199	0.23	196	0.24	225	0.27
Total # Youth Injured in Assaults by Youth	112	0.13	122	0.14	119	0.14	136	0.16
Total # of Staff Assaulted by Youth	123	0.14	173	0.20	178	0.21	156	0.19
Total # Staff Assaulted by youth resulting in Injury	18	0.02	20	0.02	33	0.04	24	0.03
Total # Incidents of Mutual Fights	355	0.41	530	0.62	570	0.69	460	0.55
Total # Mutual Fight with injury	128	0.15	148	0.17	175	0.21	110	0.13
Total # of Uses of Force	470	0.54	760	0.89	801	0.97	839	1.01
Total Mechanical Restraint Usage	307	0.35	638	0.74	604	0.73	661	0.80
Average Daily Population (In count)	483		466		458		451	

	9/04 – 2/05 CRIPA Rpt #1		3/05 to 8/05 CRIPA Rpt #2		9/05 to 2/06 CRIPA Rpt #3		3/06 to 8/06 CRIPA Rpt #4	
CRIPA Summary (AMS, RAC, BCS & CMS)	**6Mo Avg**	**Rate**	**6Mo Avg**	**Rate**	**6Mo Avg**	**Rate**	**6Mo Avg**	**Rate**
Total # calls responded to by Security	733	5.06	954	6.68	996	7.21	898	6.49
Total # of Youth Injured (all sources)	183	1.26	222	1.56	188	1.36	139	1.00
Total # Youth Assaulted by Youth	16	0.22	33	0.23	33	0.24	38	0.27
Total # Youth Injured in Assaults by Youth	9	0.13	20	0.14	20	0.14	23	0.16
Total # of Staff Assaulted by Youth	10	0.14	29	0.20	30	0.21	26	0.19
Total # Staff Assaulted by youth resulting in Injury	2	0.02	3	0.02	6	0.04	4	0.03
Total # Incidents of Mutual Fights	30	0.41	88	0.62	95	0.69	77	0.55
Total # Mutual Fight with injury	11	0.15	25	0.17	29	0.21	18	0.13
Total # of Uses of Force	39	0.54	127	0.89	134	0.97	140	1.01
Total Mechanical Restraint Usage	26	0.35	106	0.74	101	0.73	110	0.80
Average Daily Population (In count)	483		466		458		451	

	AMS		BCS		CMS		CRIPA Rpt #4	
	Total	Rate	Total	Rate	Total	Rate	Total	Rate
Total # calls responded to by Security	2032	4.08	2084	13.65	1270	7.12	5386	6.49
Total # of Youth Injured (all sources)	455	0.91	197	1.29	180	1.01	832	1.00
Total # Youth Assaulted by Youth	133	0.27	28	0.18	64	0.36	225	0.27
Total # of Youth Injured in Assaults by Youth	68	0.14	14	0.09	54	0.30	136	0.16
Total # of Staff Assaulted by Youth	39	0.08	54	0.35	63	0.35	156	0.19
Total # Staff Assaulted by Youth Resulting in Injury	9	0.02	9	0.06	6	0.03	24	0.03
Total # Incidents of Mutual Fights	287	0.58	46	0.30	127	0.71	460	0.55
Total # Mutual Fight With Injury	72	0.14	3	0.02	35	0.20	110	0.13
Total # of Uses of Force	221	0.44	441	2.89	177	0.99	839	1.01
Total Mechanical Restraint Usage	126	0.25	315	2.06	220	1.23	661	0.80
Average Daily Population (In count)	271		83		97		451	

	AMS		BCS		CMS		CRIPA Rpt #4	
	6Mo Avg	Rate	6Mo Avg	Rate	6Mo Avg	Rate	6Mo Avg	Rate
Total # calls responded to by Security	339	4.08	347	13.65	212	7.12	898	6.49
Total # of Youth Injured (all sources)	76	0.91	33	1.29	30	1.01	139	1.00
Total # Youth Assaulted by Youth	22	0.27	5	0.18	11	0.36	38	0.27
Total # of Youth Injured in Assaults by Youth	11	0.14	2	0.09	9	0.30	23	0.16
Total # of Staff Assaulted by Youth	7	0.08	9	0.35	11	0.35	26	0.19
Total # Staff Assaulted by Youth Resulting in Injury	2	0.02	2	0.06	1	0.03	4	0.03
Total # Incidents of Mutual Fights	48	0.58	8	0.30	21	0.71	77	0.55
Total # Mutual Fight With Injury	12	0.14	1	0.02	6	0.20	18	0.13
Total # of Uses of Force	37	0.44	74	2.89	30	0.99	140	1.01
Total Mechanical Restraint Usage	21	0.25	53	2.06	37	1.23	110	0.80
Average Daily Population (In count)	271		83		97		451	

* Explanation of rates: "The rates represent occurrences per 100 youth days. For example, 0.14 assaults with injury per 100 youth days means that the average youth would be involved in an assault resulting in injury every 714 days. Given ADJC's 212 day average length of stay, an average youth would have to stay approximately 3.4 times longer than the average length of stay to be injured in an assault." (Provided by Jim Hillyard.)

The charts show increases from Sept. '04 to Aug. '06 in 8 of the 10 categories. From Sept. '05 to Aug. '06 four of the categories show increases while six show decreases. It is possible that the increases in the rates from '04 are due to improvements in the reporting process.

The rates in the charts do demonstrate that violence prevention efforts are effective and the decreasing rates of violence are also consistent with interviews conducted by the Consultants Committee that indicates staff and youth are safer in their environments than they were 2 years ago.

During this last reporting period ADJC has initiated additional efforts to provide protection to youth confined in its facilities. Violence reduction plans have been developed at each facility. The Violence Reduction Plans include:
(1)Inclusion of the RAC Administrator at classification staffings to ensure timely placement of youth and consistent communication between facilities.

(2)Provide strategies for Juvenile Supervision refresher training for clinical and leader personnel

(3)Education Operations Committee formed to identify problem areas within the education, environment and develop a facility Superintendent's Management Order (SMO).

(4)Introduction and tracking of Individual Behavior Plans on DJC network hard drives

(5)Develop guiding principles and mission statement of the AMS Sting Quality Assurance and Communication team.

(6)Incorporate violence and incident reports at management debriefings

(7)Introduce ADJC ACAB Cultural Norms and develop and implement Norms Kick-off effort

(8)Incorporate ACAB within the Employee-of-the-Month selection process

(9)Train Clinical and MDT staff in areas of New Freedom (Group Dynamics) and Multi-Disciplinary Team Policy

Current Violence Reduction Plan Activities at AMS:
(1)Develop and implement housing unit after-school and weekend recreation plan centered around social development and rewards
(2)Clarify security roles and expectations in conjunction with the education Superintendent's management order
(3)Improve communication with housing unit leadership and staff
(4)Review RAC and AMS Administrator roles to ensure consistency in classifying and disseminating information regarding youth's history, victims, and potential accomplices and threats.
(5)Develop radio etiquette training and monitoring plan
(6)Assign remote desktop connection to all housing unit managers for the monitoring of staff practices and youth issues
(7)Develop unit manager quality assurance expectations
(8) Train YCO series and education staff in appropriate youth interventions through Handle with Care and Therapeutic Crisis Intervention curriculum

Expected outcomes in measurable terms: 25% reduction in reported violence by October 2006. Additional 25% reduction in reported violence by April 2007.

The other two facilities, BCS and CMS also have detailed violence reduction plans which were

reviewed during this reporting period.

Cottage Management Issues: New Freedom continues. During the June site visit youth were interviewed and expressed their dislike of the program. This information was passed on to the Leadership Team at the site visit de-briefing on June 7. It is not surprising that youth do not like the programming. It is a major change in their routine and creates much more structure in their daily routines than they have previously experienced. It is not necessary that the youth like the program for it to be effective however it is anticipated that once the program is fully implemented and becomes the expected routine for youth coming into the facility without previous living experience in the ADJC that the program will gain acceptance.

All of the consultants attended a presentation of the program in a March site visit.

During the next reporting period the violence reduction plans at each facility will be reviewed for progress and attainment of measurable goals in violence reduction.

Recommendation: Continue the training and implementation of New Freedom**.** Document the progress of the violence reduction plans in each facility.

Documentation: Meetings with Leadership team at June site visit de-briefing. Review of the violence reduction plans forwarded vial electronic mail in August, 2006.

UFN 4.2.2 Each youth entering the facility shall be given an orientation that shall include simple directions for reporting abuse and assuring youth of their right to be protected from retaliation for reporting allegations of abuse.

Status: Substantial Compliance

Discussion: Youth have been interviewed at each of the facilities, randomly selected from a daily roster and these youth have verified that they received an orientation in the RAC as they entered the system and each received a handbook**.** They indicated that they had been told of their right to be protected and to report abuse.

Recommendation: It is recommended that during the orientation process and the distribution that the contents of the handbook be reviewed with all of the youth. In some instances youth indicated that they had received the book without explanation. Issues of literacy, language skills, etc. require that the contents be carefully reviewed with the youth in addition to the distribution of the book.

Documentation: Interviews with youth during June site visit at each facility.

UFN 4.2.3 In collaboration with the local office of Child Protective Services and with local law enforcement, the facilities shall develop and implement policies and procedures regarding steps that must be taken immediately upon the reporting of an allegation of abuse in order to preserve evidence and to protect youths pending an investigation of the abuse.

Status: Substantial Compliance

Discussion: In previous reports it has been clarified that the I&I unit of ADJC will conduct its own investigations. This process has been reviewed and approved by both parties to this settlement agreement. When I&I becomes aware of conditions that existed in the community that affected a youth in custody that information is transmitted to the appropriate CPS and law enforcement agency. Three examples of that were reviewed during the June, 2006 site visit. One youth reported, during the intake process at AMS, that he had been abused by adult males. This information was given to the local CPS office. A female, during intake also reported having been sexually abused by her mother's boyfriend. This was reported to CPS and law enforcement by I&I. Another female had lice when being admitted. She told staff of being denied medicine for this by her mother as well as her mother not allowing her to fill prescriptions, at no cost to her, for the girls emotional problems. I&I sent this information to CPS for a neglect investigation. In previous reports the issue of an external oversight process has been included in this section of the report. ADJC has also posted, in each of the facilities, information that allows youth to inform Arizona Peace Officers Standards and Training if they believe that an investigator with the ADJC I&I Division committed an act of police misconduct. Director Branham has written a letter to the Governor's Task Force on Juvenile Corrections Reforms recommending the formation of an Arizona Department of Juvenile Corrections (ADJC) Director's Advisory Board. The formation of the Board will await action by the Governor.

Recommendation: (Required): During the remainder of the settlement agreement the development of the Citizens Advisory Board be monitored. Audits of I&I conducted by ADJC should be carefully examined.

Documentation: Review of cases provided by I&I Administrator John Dempsey. Review of notice posted in ADJC facilities informing youth of their right to inform AZPOST of concerns about ADJC I&I Investigations misconduct.

UFN 4.2.4 Each youth who reports to the Health Unit with an injury shall be questioned by a nurse or other health care provider outside the hearing of other staff or youths, regarding the cause of the injury. If, in the course of the youth's infirmary visit, a health care provider suspects abuse, that health care provider shall immediately:

Status: Substantial Compliance

Discussion: This UFN continues in Substantial Compliance. The Health Unit reports any suspected abuse to I&I which then conducts the appropriate investigation. QA is in the process of conducting audits and those audits contain reviews of the health unit. Those audits will be reviewed as part of the compliance process for the remainder of the monitoring process.

Recommendation: The recommendation from the 2nd report is continued. Monitor the healthcare report card through the QA process.

Documentation: CRIPA Action Plan. CMS QA site visit of Feb. 27-28-06. Discussion with leadership team during June, 2006 site visit.

UFN 4.2.4.1 Take all appropriate steps to preserve evidence of the injury (e.g. photograph the

injury and any other physical evidence);
Status: Substantial Compliance
Discussion: This process as has been reported in previous reports continues. In the last report the recommendation was that contacts with the SANE nurse be reviewed during this reporting period. One incident was reviewed in order to verify the contact and the reporting process.
Recommendation: None
Documentation: Discussion with John Dempsey during June site visit. Review of SANE documentation.
UFN 4.2.4.2 report the suspected abuse to the investigations and Inspections Unit, which shall in turn report it to the local Child Protective Services office;
Status: Substantial Compliance
Discussion: The process for reporting has been reviewed and agreed upon as documented in the last report. The nurses, in each of the facilities, upon any suspicion of abuse report the incident to the I&I which has responsibility for investigating. During reporting period examples of investigations that were referred to CPS have been reviewed**.**
Recommendation: None at this time.
Documentation: Review of cases that had been investigated by I&I and referred to CPS.
UFN 4.2.4.3 document adequately the matter in the youth's medical record; and
Status: Substantial Compliance
Discussion: During the last reporting period Dr. Kraus reviewed the documentation. In addition the issue of communication with I&I was reviewed. It is now understood that nursing staff can contact I&I directly regarding any concerns they may have regarding the referral of a youth for abuse and the handling/disposition of the incident by I&I. It was understood that I&I would not, due to confidentiality concerns, routinely inform nursing staff of the results of investigations but would respond to inquiries from nursing staff on a case-by-case basis**.**
Recommendation: None at this time.
Documentation: Further discussion of this matter with John Dempsey, I&I Administrator during the June site visit at AMS.
UFN 4.2.4.4 complete an incident report.

Status: Substantial Compliance
Discussion: The incident reporting process continues as outlined in the 2nd and 3rd reports. The process was reviewed again with John Dempsey, I&I Administrator during the June site visit at AMS. The reports are being completed, processed electronically, sorted as to administrative and criminal and assigned to appropriate staff.
Recommendation: Continue tracking of IR's for compliance.
Documentation: Meeting with John Dempsey, I&I Administrator during the June site visit.
UFN 4.2.5 Within six months of the effective date of this Agreement, the State shall develop and implement policies directing how, when, and to whom (including to Child Protective Services, law enforcement officials, and/or facility administrators) allegations of abuse shall be referred and investigated. A referral to Child Protective Services shall be made in accordance with Arizona state law, and an abuse investigation shall be warranted, whenever;
Status: Substantial Compliance
Discussion: The Process has been outlined in the previous reports. That process continues to operate as described. In the last report the recommendation was that a review of investigations by Director Branham would be conducted. I&I Administrator Dempsey provided samples of investigations that had been conducted and were requested for review by Director Branham. During the exit debriefing of the June site visit this matter was also discussed and the review process once again verified.
Recommendation: Continue to provide the consultants with examples of investigations and review by Director Branham**.**
Documentation: Review Directors request to I&I Administrator Dempsey of 10/19 2005, 4/30/2006 and 5/22/06.
UFN 4.2.5.1 a health care provider, staff or youth reports suspected abuse; or
Status: Substantial Compliance
Discussion: The process has been outlined in the previous reports. Health care personnel have been informed by I&I that they can contact I&I for information regarding the status of cases. It was agreed that information would not be routinely forwarded but handled on a case-by-case basis with personnel in each facility. (See UFN 4.2.4.3)
Recommendation: None at this time**.**
Documentation: Discussion with John Dempsey during the December site visit**.**
UFN 4.2.5.2 an incident report, use of force report, injury report, grievance or other source of

information provides a credible basis for concluding that abuse may have occurred.
Status: Substantial Compliance
Discussion: The process was reviewed in detail in the last report. In addition it was recommended that the investigative process be reviewed once again with I&I for consistency across facilities. During the June site visit at AMS John Dempsey, I&I Administrator walked through that process. The policy & procedures are in place and the investigative and reporting protocols are part of ADJC not each separate facility. The investigators are part of the I&I Unit housed at the central office and are assigned cases based on the review of the incidents by Mr. Dempsey and Director Branham. Incidents reports, use of force reports and grievances have all been reviewed during the compliance period.
Recommendation: Provide the consultants examples of investigations at each facility during the next reporting period.
Documentation: Discussion with John Dempsey, I&I Administrator during the June 2006 site visit at AMS. Review of Policy and procedure No. 1160.01. Effective 10/26/04.
UFN 4.2.6 Effective six months from the effective date of this Agreement, the facilities shall provide appropriate behavior management/crisis intervention training to staff before staff may work in direct contact with youths.
Status: Substantial Compliance
Discussion: The training continues as Academies are scheduled and held on a regular basis. The curriculum that was outlined in the last report must be completed and competency tests passed before employees may begin work in the cottages within the ADJC secure facilities. In the last report concern was expressed about the low compliance rate with TCI training at CMS. Through December 30, 2005 the rate was 38%. Through August 10th, 2006 that compliance rate is at 65%. An additional 58 staff have been scheduled for training which will begin on August 11th and continue through the end of the year. An updated Compliance Report dated 8/06 was forwarded for review. The format did not allow for a determination of total compliance percentages.
Recommendation: Update the Consultants on rates of compliance and change the reporting format for easier connection of curriculum with compliance rates.
Documentation: Meeting with Vickie White, Megan McGlynn during the July site visit**.** Review training schedule and compliance rates.
UFN 4.2.7 All staff shall continue to complete successfully competency based training in behavior management/crisis intervention before working directly with youths.

Status: Substantial Compliance
Discussion: In the last report it was recommended that content based evaluations of training be conducted. Vickie White provided this update: "As per the consultants' recommendation, ADJC Staff Development and Training Division has formalized an Annual Curriculum Review Process. To begin this process, a list has been comprised of the course curriculum that is currently active (both Pre-service and In-service). The date of which the curriculum was designed and/or last reviewed will be our starting point. Beginning in October 2006, on a quarterly basis the curriculum will be distributed to the Subject Matter Leader (SML) who will enlist the assistance of a Subject Matter Expert (SME) if other than the SML to complete a thorough review of the curriculum. (Refer to Curriculum Review Draft.) Upon completion of each review, the curriculum will be updated as needed and returned to active status. There are currently 40 courses on the Review List. (10) courses will be reviewed per quarter." A listing of courses reviewed through 2005 was reviewed.
Recommendation: Consider installing the coaching teams once again. This not only tests competency but allows for the review of proper implementation of P&P by all staff.
Documentation: Meeting with Staff Training and Development Administrator Vickie White and Megan McGlynn during the July site visit. Review of electronic correspondence from Vickie White, August 2006.
UFN 4.2.8 The State shall evaluate regularly the training and the trained techniques through quality assurance data (including data correlating use of force incidents and abuse allegations with data measuring the efficacy, occurrence of, and staff participation in training programs), Performance based standards data, evaluations from training program participants, Incident Review Team reviews of use of force incidents, abuse investigation reports, interviews with staff and youths, and other means evidencing the efficacy of the trained techniques in managing behaviors and crisis interventions at the facilities. As warranted, the facilities shall adjust the training curriculum based on such evaluations.
Status: Substantial Compliance
Discussion: There was considerable confusion regarding this UFN during the last reporting period. The Consultants Committee had discussed the need for a continued review of the curriculum as part of the QA process. That was clarified with Vickie White and Megan McGlynn during the July site visit and it will be wrapped into the QA process when reviewing the academies and the training curriculum. The QA process is in place and the audits are reviewing training. The review of use of force and handle with care curriculum is scheduled for July 30, 2006. Additional QA activities are scheduled for August 10, 2006 to continue reviewing training.
Recommendation: Inform the Consultants Committee of any changes in the curriculum for their input and provide them with curriculum evaluations.
Documentation: Meeting with Vickie White and Megan McGlynn during the July site visit.

Review of QA review of use of force and handle with care.

4.3 Staffing

UFN 4.3.1 The DOJ acknowledges that the State has embarked on a plan to add necessary additional direct care staff positions. The State shall ensure that there are sufficient numbers of adequately trained direct care and supervisory staff to safely supervise youth and protect youth from harm.

Status: Partial Compliance

Discussion:

Because of the physical plant design of cottages located at the AMS and BCS campuses physical capacity can accommodate more than 24 youth. However, best practice suggests that cottages should not exceed 25 youth.

During the 1st reporting period there were not cottages reporting more than 28 youth in any one cottage.

During the 2nd reporting period, due to increases in population there were 6 cottages with more than 28 youth.

During the 3rd reporting period 3 cottages had 32 or more youth.

Again during this reporting period 3 cottages have 32 or more youth assigned. These cottages are all located at AMS (Freedom, Kachina, and Recovery)

Once a cottage has 28 or more youth assigned, authorized line staff positions are increased for a 32 bed cottage.

For FY 2007 (July 1, 2006 – June 30, 2007), ADJC, including EPS, has a funding / position allocation for 637 youth with an actual youth count of 606 on 7/19/06.

	Reporting Periods		
	2nd	3rd	4th
AMS	313	292	284
CMS	116	108	94
BCS	96	94	90
EPS	141	136	138
Total	666	630	606
Less EPS	525	494	468

The current funded direct care staffing at ADJC shows:
2-3-2 staffing for a 24 youth cottage. This would be ratios of 1:12, 1:8 and 1:12.
3-4-2 staffing for a 32 youth cottage. This would be ratios of 1:11, 1:8 and 1:16.

While the ADJC has been authorized the appropriate positions, the issues continue to be the recruitment and retention of staff. The following table contains vacancy rates for cottage staff by each reporting period.

	Reporting Periods		
	2nd	3rd	4th
YCO I/II	22%	22%	33.6%
YCO III/Sgt	63%	11%	4.4%
YPO III	37%	30%	7.1%
PA II	25%	26%	0.0%
YPS/Lt/Capt	8%	2.5%	7.9%

Most of the higher level positions (YCO III and YPO III) that were created in the last 12 months have been filled by internal promotions. This has resulted in more vacancies for entry level positions (YCO I/II).

While the ADJC continues to make efforts to respond to recruitment and retention issues overall vacancy rates have not changed dramatically since the last reporting period. Competitive salary is a major component that addresses recruitment and retention of YCO staff. Since January 2004, the starting salary for YCOs has increased 28%. Current starting base salary for YCOs is $29,958. In addition, At-Risk Performance Pay ($665) and a Uniform Allowance ($300) has been added for a total taxable starting annual salary of $30,923. For the first time in three years, ADJC starting salary for YCOs is somewhat competitive with Maricopa ($31,180) and Pima ($33,700) counties.

The QA audits continue to document staffing ratios and these are reviewed as part of the monitoring process. The issue of overtime continues to need oversight and will be stressed during the next reporting period. The issue of efficiency and competence was raised during the last reporting period and needs to be a concern until recruitment and retention of staff allows for the reduction in overtime usage.

In the last report a recommendation regarding verification of critical posts was made. It may be that this has been addressed but it was not documented during this last reporting period. Also, the documentation of overtime usage needs to be reviewed by the Committee of Consultants.

Recommendation: (Required) In addition, Security captains at each facility on each shift should verify presence of staff at critical posts through random checks that are documented. ADJC should also document shift coverages in each facility to determine hours being worked, by whom, in order to determine maximum hours allowed in any one period. ADJC should also review staff coverage, overtime, with incidents to determine if patterns exist that would instruct changes in policy regarding coverage limits.

Documentation: Material provided from Debra Peterson in electronic mail of 8.24.06. Discussion during site visits with Debra Peterson, superintendents of facilities.

UFN 4.3.2 The State shall continue to ensure that there are adequate staff to provide adequate security for the facilities; permit youth to use the bathroom facilities in a timely manner and

provide a sufficient level of supervision to allow youth reasonable access to medical and mental health services, education, and adequate time spent in out-of-room activities.
Status: Substantial Compliance
Discussion: The audits being conducted by the QA does look at access to medical and mental health services. All of the consultants have access to these audits and are able to review this access. The audits show that their access is there and that youth are accessing medical, mental health, and education services. In addition the management reports that track access to the bathroom facilities, 10X7's were reviewed for March. Those reports showed that the majority of youth had responses to bathroom requests within several minutes. The longest wait was one 12 minute and three 9 minute waits at AMS. The CMS forms were not completed and therefore the waits could not be determined through the management reports. In discussions with staff it was clear that security made this a priority and youth were not being made to wait for bathroom access. The interest in closing dry cottages is still there but no firm decisions have been made for future closures.
Recommendations: Adjust the management reports from CMS so that they are the same as those at AMS.
Documentation: Discussion with Supt. Jericho and review of 10X7 management reports during the July site visit**.**

4.4 ADJC's Investigations and Inspections Unit and Quality Assurance Team
UFN 4.4.1 ADJC has created the Investigations and Inspections Unit within ADJC to consolidate and supplement quality assurance activities already undertaken by ADJC in accordance with this Agreement. ADJC has hired, from outside ADJC, an Administrator for the Investigations and Inspections Unit, who reports directly to the Director of ADJC. ADJC shall continue to provide the administrator with sufficient staff and resources to perform the tasks required by this Agreement.
Status: Substantial Compliance
Discussion: Pursuant to Section III.H.5 of the Memorandum of Agreement (MOA), this section of the MOA is terminated from the agreement and no longer subject to monitoring, based upon a finding of "substantial compliance" for at least 18 months.
UFN 4.4.2 ADJC shall create a Quality Assurance Team, the Administrator of which shall report directly to the Director of ADJC. The Quality Assurance Team shall work in conjunction with the Investigations and Inspections Unit.

Status: Substantial Compliance
Discussion: The QA Office is functioning and audits are being conducted. Those audits are being reviewed by the Consultants and are being utilized by Director Branham and the leadership team to continue to identify management issues and provide appropriate responses to them.
Recommendation: (Required) Continue to provide audits to the Consultants for review during the remainder of the monitoring period.
Documentation: Review of recently conducted audits.
UFN 4.4.3 The Investigations and Inspections Unit and the Quality Assurance Team, in Coordination, shall be responsible for the following tasks:
UFN 4.4.3.1 monitoring compliance with Department policies and procedures in the facilities, with emphasis on policies and procedures relating to issues addressed in this Agreement;
Status: Substantial Compliance
Discussion: Audits continue to be conducted and shared with the Consultants.
Recommendation: Continue to provide audits to the Consultants targeting areas of the settlement agreement still requiring work for substantial compliance.
Documentation: Review of audits provided by QA Office. AMS audit of March 06, BCS audit of Sept 05, AMS Audit of July 05, CMS audit of May 05.
UFN 4.4.3.2 conducting audits and other quality assurance activities as described in 4 (d) below;
Status: Substantial Compliance
Discussion: The first audit was conducted by the QA and I&I divisions on March 23-25, 2005 at CMS. The second audit conducted at AMS in July, 2005. Those audits have been forwarded to the Consultants for their review and use in their monitoring work. As additional audits have been completed they have all been forwarded to the Consultants Committee for their review. Audits are scheduled and conducted as part of the business of the agency at this time.
Recommendation: Continue to forward audits to Consultants Committee as they are completed.
Documentation: Review of completed audits.
UFN 4.4.3.3 reviewing and, where appropriate, investigating allegations, of child abuse;
Status: Substantial Compliance
Discussion: In the last report the process was outlined. During the June 2006 site visit staff

misconduct cases were reviewed with John Dempsey, I&I Administrator. In addition, a staff misconduct investigation was reported to the committee of consultants in last June by Director Branham as part of the monitoring process. Discussions were held regarding the incident and the handling of it by the I&I. In this particular investigation both staff involved were terminated and the process as reviewed was both timely and thorough.
Recommendation (Required): None at this time.
Documentation: Meeting with John Dempsey during June 2006 site visit at AMS. Discussions with Director Branham during a staff misconduct investigation in late June and receipt of incident information, investigation process and disposition of the investigation by John Dempsey, I&I Administrator.
UFN 4.4.3.4 assuring the implementation and adequacy of the educational, medical, and mental health quality assurance programs required by this Agreement; and
Status: Substantial Compliance
Discussion: Reviewed with Megan McGlynn the most recently completed audits and the sections that address the educational, medical and mental health components. The QA unit now reviews each of these areas in each audit and those audits are available for the consultants to review.
Recommendation: Invite comments from the consultants in each of these areas as audits are completed.
Documentation: Discussion with Megan McGynn, QA Administrator during the July site visit and review of audits.
UFN 4.4.3.5 coordinating quality assurance activities performed by various Division offices to prevent unnecessary duplication of efforts.
Status: Substantial Compliance
Discussion: Each office or division submits the audit questions to Megan McGlynn and her staff and the audits are then developed from those submissions. This includes the purpose statement, standards, P&P and expected outcomes. This allows the correct questions to be asked as well as to prevent duplication of efforts as audits are conducted in various divisions and facilities.
Recommendation: None at this time.
Documentation: Meeting with Megan McGlynn during July Site Visit and review of completed audits to demonstrate how duplication is prevented.

UFN 4.4.4 The Quality Assurance Team, in collaboration with the Inspections and Investigations Unit, shall create and implement a written quality assurance program, as defined in the Definitions Section of this Agreement, as supplemented below:
Status: Substantial Compliance
Discussion: The quality Assurance program is fully operational. The audits were reviewed by the leadership team and corrective action plans developed and implemented. These audits are forwarded to the Consultants' Committee and used in the monitoring process. During the last reporting period it was agreed that Child Protective Services (CPS) would not be reviewing investigations conducted by ADJC. The reasons for that are explained in UFN's 4.2.3, 4.2.4.2 & 4.2.5. As part of that discussion it was agreed by all parties that the Quality Assurance Division of ADJC would conduct audits of I&I investigations, providing ½ of the recommended oversight necessary for the integrity of the process. That responsibility has been incorporated as part of this UFN. In response to this ADJC has developed Policy 1050 and Procedure 1050.06 Quality Assurance Investigations Review Committee. The purpose of this P&P is that the Arizona Department of Juvenile Corrections (ADJC) Director ensures appropriate oversight of investigative functions by establishing a committee that randomly reviews investigations. The team has met 3 times and has reviewed investigations. There are still questions about how this process will work and it will continue to be reviewed. However, the Department has put in place what is necessary for the oversight to be complete and effective.
Recommendation: (Required). Review of P&P 1050.06. Continued discussions with Megan McGlynn and John Dempsey during the July site visit.
Documentation: Review of QA plan with QA administrator and review of completed audits.
UFN 4.4.4.1 The comprehensive audits as specified in the Definitions Section shall include:
UFN 4.4.4.1.1 inspection of institutional, medical and educational records, unit logs, incident reports, use of force reports, major disciplinary reports, documentation of room checks by line staff, etc.
Status: Substantial Compliance
Discussion: Reviewed audits of the facilities with emphasis on institutional, medical and educational records, logs, IR's etc. The audits all contain documentation that satisfy this UFN.
Recommendation: Continue to send audits to the Consultant's Committee.
Documentation: Review of audits with Megan McGlynn at the July site visit.
UFN 4.4.4.1.2 Interviews with staff, administrators, and youth at each facility;

Status: Substantial Compliance
Discussion: Reviewed audits documenting the interviews.
Recommendation: None at this time.
Documentation: Meeting with Megan McGlynn during the July site visit and review of audits.
UFN 4.4.4.1.3 where appropriate, interviews with the parents or other care givers of youth confined in the facilities;
Status: Substantial Compliance
Discussion: Surveys are sent to the parents and these are compiled for discussion in the audits.
Recommendation: None at this time.
Documentation: Meeting with Megan McGlynn, QA Administrator during the July site visit.
UFN 4.4.4.1.4 inspection of the physical plant;
Status: Substantial Compliance
Discussion: Inspections of the physical plants have been included since the first audit.
Recommendation: None at this time**.**
Documentation: Review of past audits with Megan McGlynn during the July site visit.
UFN 4.4.4.1.5 determination of compliance with the facilities' policies, including those relating to: suicide prevention, staffing levels and youth supervision, use of force, disciplinary practices, positive behavior management programs, grievance procedures, sanitation, youth-on-youth violence, conditions in security units, adequacy of counseling and rehabilitative services, and the adequacy of all facility documentation; and
Status: Partial Compliance
Discussion: The language below is from a memo sent to the Consultant's Committee from Danny Thompson, Policy/Procedure Unit, dated July 27, 2006. "Specific to the UFN most policies and procedures are still under development with a committee with a few exceptions noted below. The 1120/04/05/06/07 Medical records series are still in the development phase with Dr. Kellie Warren and the Medical/Mental Health policy development committee. 3000.08 Organization of Health Records, 3000.09 Confidentiality of Health records, and 3000.11 Medical Record Storage. Dr. Warren and the Mental Health Committee will review these drafts. Medical/Mental Health record integration and automating those records on line is projected to occur in August

2006.

The 2303.02 Disciplinary Action Plan did not receive any drafts or source information from Jim Hillyard, the Previous Assistant Director. This will be addressed by Dr. Warren recently appointed Assistant Director of Programs and Institutions and the newly organized secure facility policy development committee.

4025.03 Culinary Arts Program is still in the development phase with Dr. Moreno and Dr. Jude Lanphar. There are monthly workforce development meetings taking place to address these issues.

4061 Separation Program-The Separation series is being reviewed and revised by the secure facility policy development committee under Dr. Warren, Assistant Director of Programs and Institutions. The focus of the policy development committee is to make separation for de-escalation and stabilization only. The 4061.01, 4061.02, and 4061.04 procedures are being combined into one new separation procedure.

Policy 44203 Mental Health Evaluations and procedure 430-3.02 Juvenile Mental Health Assessment-Dr. Warren is presently rewriting completed drafts by Lee Underwood and Dr. Thomas Seymour which will soon be ready for agency posting. Procedure 4203.03. Criminogenic and Protective Factors Assessment has been routed and edited and awaiting final approval from Dr. Warren. Procedure 4203.04 Referrals for Mental Health/Psychiatric Services and Psychotropic Medication Management at Secure Care Facilities is presently posted awaiting agency feedback. Procedure 3025.01 Consent for Psychiatric Services is presently posted on the internet.

The 4210/01/02/03/04/05 Individual Counseling series are being rewritten and addressed by the Mental Health Policy development committee. Dr. Warren plans on revisiting this area after the Mental Health Assessment and CAPFA have been completed. She plans on incorporating classification, time frames, and acuity of care in order to update and/or replace outdated procedures and the previously written drafts.

4242.02 Juvenile Drug Testing for Federally Funded Recovery Programs (Urinalysis for the Recovery Program). Dr. Warren, Julie Treinen, Substance Abuse Coordinator, and David Stewart Substance Abuse Consultant are updating this existing in-house procedure.

4484 Work Experience Program is in the process of being further developed, rewritten, and addressed by Dr. Moreno/Lanphar and the workforce development team."

In addition, Policies 2515.01 and 4040 do not exist. These were erroneously referenced in the last report.

Recommendation: Provide updates to Consultant's Committee on the progress of these P&P's.

Documentation: Memo from Policy and Procedure staff, July 2006.

UFN 4.4.4.1.6 A written report recording the findings of the audit.

Status: Substantial Compliance

Discussion: Audits are conducted and each audit has been forwarded to the Committee of Consultants for review and comments.

Recommendation: Inform the Consultant's Committee of completed audits and issues that might need attention for coming site visits.

Documentation: Reviewed findings of audits with Megan McGlynn during the July site visit.

UFN 4.4.4.2 Unannounced periodic site visits will occur at each facility. Investigations and Inspections Unit staff and the Quality Assurance Team shall have complete and unimpeded access to the facilities, their records, staff, and residents. Staff at the facilities shall be informed of their obligations to cooperate in all Investigations and Inspections Unit and Quality Assurance Team operations.

Status: Substantial Compliance

Discussion: Reviewed the write-up on an unannounced site visit to BCS on May 27th 2006. Visit occurred at 7:30 a.m. Issues identified at that visit included:
Officer in charge had not reported for duty.
Unit Success had insufficient staff coverage
4 of 6 rooms at Success were clean and tidy 2 were not.
Log Book showed 7 of 10 pages had dates and were legible.

Unit Maya:
2 youth in room on exclusion (privacy time)
2 of 4 rooms were clean and tidy.
9 of 10 pages in log book had dates and were legible.

Unit Recovery
6 of 6 rooms checked were neat and orderly.
4 of the 10 pages in the log book had dates.
Youth in Separation had no blankets.

Positive observations:
Staff were wearing 911 extraction knife (fanny packs)
There was a program posted in the cottage day rooms.
Venture youth were involved in a quilting project that they took great pride in.
Staff were documenting in log books sharps counts, shift changes and other pertinent information.
Staff were helpful and polite and interacting with youth appropriately.

The following is a listing of unannounced site visits during this last reporting period.

5/20/06-AMS
5/27/06-BCS
5/30/06-AMS
6/30/06-EPS
7/28/06-BCS
8/20/06-EPS
8/5/06-AMS/BCS
8/22/06-AMS

Recommendation: (Required). Continue to provide a list of unannounced visits conducted during the last reporting period and the report of those visits for review by the Committee of Consultants.

Documentation: Review of AMS and CMS audits.

UFN 4.4.4.3 Investigation of significant incidents (as defined by the Administrator of the Investigations and Inspections Unit) shall include: Deaths; serious injuries or hospitalizations; suicides and serious suicide attempts; escapes or other serious breaches of security; and medical emergencies. The investigation shall result in a written report to the Director of ADJC and shall include findings and recommendations. The Director of the Investigations and Inspections Unit shall issue protocols for coordination of such investigations with other law enforcement, administrative disciplinary, or other quality assurance investigations.

Status: Substantial Compliance

Discussion: In the 2nd Semi-Annual Report the process for reporting serious incidents was outlined. This process was once again reviewed with John Dempsey, I&I Administrator during the July site visit. Cases are all reviewed by the Director.

Recommendation: None at this time.

Documentation: Meeting with John Dempsey, I&I Administrator during the July site visit.

UFN 4.4.4.4 Review of all incidents of use of force and the use of separation in excess of 24 hours shall be conducted. The Investigations and inspections Unit shall be sent copies of every use of force report. The Administrator of the Investigations and Inspections Unit shall establish criteria under which such incidents shall be independently investigated for compliance with the facilities' policies. Such criteria shall include review of all incidents of use of force resulting in serious injury or hospitalization.

Status: Partial Compliance

Discussion: During the June site visit there was some confusion regarding the review of use of force. In discussions with AMS staff it was reported that a decision is made at the facility level regarding the reporting of the use of force. This was contrary to what had been reported in earlier reports. (See process outline in the last report.) During the de-briefing this issue was

raised with Director Branham and the leadership team. Director Branham said that he personally reviewed the IR's each day and John Dempsey, I&I Administrator reiterated the previously understood policy that all uses of force were reviewed by I&I. However, since the discussion we had was with a senior administrator at AMS it seemed clear that the policy was not completely understood and it was certainly possible that all uses of force were not being sent to I&I. At least not all of those from AMS. This needs to be clarified in more detail during the next reporting period. In addition, the issue of medical being aware of injuries that may not have been reported through an IR was raised. Presumably any youth who requires medical attention would also be the subject of an IR. It seems logical that the medical unit report injuries to I&I. In order to prevent duplication the submission of the IR could be tracked by the medical unit or it could just be submitted routinely and then handled administratively at I&I. In the last report it was indicated that procedures are different in each facility. This process and its consistency will be monitored during the next reporting period.

During the July site visit separation units were visited at both AMS and BCS. In both instances there were 4 youth in separation. Data was also reviewed from June 2006:

A request was made during the July site visit that updated information on the use of separation be forwarded for comparison purposes. That data was not received by the August 15 deadline and so could not be analyzed. The rating of Partial Compliance will continue due to the need for more information in this area.

In the last report there was discussion about the use of force and the review of those incidents. Those reviews have begun and need to continue during the next reporting period.

Recommendation: The Youthbase data tracking system should be enhanced and used to monitor youth release times and dates. (Part of CMS audit recommendation).

Documentation: Discussions with Separation staff at all three facilities. Discussion with Joe Jericho regarding the need for documentation on use of separation.

UFN 4.4.4.5 Review of grievances raising significant issues (as defined by the Administrator of the Investigations and Inspections Unit) shall be conducted.

Status: Substantial Compliance

Discussion: These grievances are routed to I&I. Any use of force or staff misconduct are reviewed every morning, except weekends by I&I staff. They are then routed to the appropriate investigator.

Recommendation: None at this time.

Documentation: Confirmation of process with John Dempsey during the July site visit.

UFN 4.4.4.6 When, through audits, investigations or other quality assurance activities, there are findings of substantial non-compliance with the requirements of the facilities' policies or this

Agreement, a plan of correction shall be developed.
Status: Substantial Compliance
Discussion: Previous language is repeated**:** Corrective action plans, called improvement plans have been provided through the QA Office for audits conducted at CMS and AMS during this last reporting period. Those Improvement Plans have been reviewed. They contain a target area, the specific problem, goals, action steps, responsible person, start date, completion date, compliance checks, the person responsible for the compliance checks and the target completion date.
Recommendation: (Required) Continue to provide to the Consultant's Committee copies of the Improvement Plans as audits are completed.
Documentation: Audit of AMS of 6/26-30.
UFN 4.4.5 ADJC shall hire sufficient numbers of qualified investigators for the Investigations and Inspections Unit to permit prompt and thorough investigations of all allegations of abuse, including incidents of violence, use of force, serious injury or sexual misconduct. ADJC shall also ensure the investigators are provided initial and on-going training, and review and ensure the quality of all Investigations and Inspections Unit investigations.
Status: Substantial Compliance
Discussion: The I&I Unit is active and conducting investigations. The investigators and inspectors have a full training curriculum. The QA Office is conducting reviews of I&I investigations.
Recommendation: Forward to the Consultant's Committee QA of I&I when completed.
Documentation: Meeting with John Dempsy, I&I Administrator and Megan McGlynn during the July site visit.
UFN 4.4.6 ADJC shall develop and implement policies and procedures specifying that abuse investigations may be initiated by Investigations and Inspections Unit staff's review of grievances, incident reports, use of force reports, and injury reports when it appears that abuse may have occurred but was not reported. Abuse investigations also may be initiated by Investigations and Inspections Unit staff as a result of staff tours of facilities and interviews with youth, parents, or staff.
Status: Substantial Compliance
Discussion: The I&I Unit continues to conduct investigations. IR's are reviewed daily and assigned to investigators as required by the seriousness of the incident. These Investigations have been reviewed by the Consultants each quarter.

Recommendation: Continue to review with the Consultants investigations prompted by interviews with youth, parents or staff.
Documentation: Meeting with John Dempsey during the June site visit. Review of investigations forwarded by John Dempsey.
UFN 4.4.7 The Administrator of the Investigations and Inspections Unit shall issue policies and procedures regarding steps that must be taken upon the reporting of an allegation of abuse in order to preserve evidence and protect youth pending an Investigations and Inspections Unit investigation.
Status: Substantial Compliance
Discussion: Pursuant to Section III.H.5 of the Memorandum of Agreement (MOA), this section of the MOA is terminated from the agreement and no longer subject to monitoring, based upon a finding of "substantial compliance" for at least 18 months.
UFN 4.4.8 The Administrator of the Investigations and Inspections Unit shall develop and implement an Investigations Manual and training program for abuse investigations. The Training shall include specific instruction by qualified individuals on the conduct of abuse investigations relating to youth, and investigations within a correctional setting, and shall include an annual in-service training requirement.
Status: Substantial Compliance
Discussion: See 2nd report for review of the training.
Recommendation: None at this time.
Documentation: Confirmation during the July visit of the on-going training. Reviewed P&P 1160, 116007, 116014, 116015.
UFN 4.4.9 The Administrator of the Investigations and Inspections Unit shall ensure that the Investigations Manual contains guidance and information regarding the following requirements:
UFN 4.4.9.1 An interview with the alleged victim and perpetrator:
Status: Substantial Compliance
Discussion: In Substantial Compliance, manual has been reviewed during each site visit.
Recommendation: None at this time**.**
Documentation: Review of manual. Discussion with John Dempsey, I&I Administrator and Grady Daniels, ADJC Legal Division during last two site visits.

UFN 4.4.9.2 Identification and interview of all possible witnesses, including other youth and staff in the building or unit at the time of the incident;
Status: Substantial Compliance
Discussion: During the June Site visit additional investigations were reviewed and discussed with John Dempsey, I&I investigator.
Recommendation: None at this time.
Documentation: Reviewed cases during June site visit.
UFN 4.4.9.3 Examination of the youth and staff member's institutional and personnel records, including any prior allegations of abuse against the staff person whether substantiated or not;
Status: Substantial Compliance
Discussion: Reviewed several on-going investigations with John Dempsey, I&I Administrator to verify process.
Recommendation: Prepare a summary for the next site visit of investigations for review by the consultant.
Documentation: Meeting with John Dempsey, I&I Administrator during the July site visit.
UFN 4.4.9.4 Examination of any potentially relevant medical records; and
Status: Substantial Compliance
Discussion: This was outlined in the last report.
Recommendation: Provide an update to the Consultant's Committee by I&I of its revision to this manual and any examination of medical records in investigations.
Documentation: Discussion with John Dempsey I&I Administrator and Grady Daniels, ADJC Legal Division**.** Policy 1160.04. Memo from John Dempsey to Russ Van Vleet dated August 9, 2005.
UFN 4.4.9.5 Determination whether any facility staff knew of but did not report the alleged abuse, or provided false information during the investigation.
Status: Substantial Compliance
Discussion: Reviewed case file that demonstrated the process. There was an incident at CMS in June. The investigation was very thorough and dealt with a staff member who had supplied false information during an investigation.

Recommendation: Continue to review with I&I investigations that demonstrate the process of conducting the investigations**.**
Documentation: Review of case file of 7-26-06.
UFN 4.4.10 The Administrator of the Investigations and Inspections Unit shall continue to ensure that a written report of each investigation of an allegation of abuse is produced. The report shall describe steps taken during the investigation, the information obtained, and the factual conclusions reached by the investigators finding the allegation substantiated, not resolved or unfounded. The Investigations and Inspections Unit shall continue to keep records of all of its investigations, and any disciplinary action taken in response to the investigation, including investigations that do not substantiate abuse.
Status: Substantial Compliance
Discussion: Reviewed investigations with John Dempsey verifying that the P&P is followed during the investigative process. Written reports are issued and they follow the P&P that is in place that guides this process**.**
Recommendation: None at this time.
Documentation: Discussion with John Dempsey, I&I Administrator and electronic mail from John Dempsey of 8/7/2006.
UFN 4.4.11 The Director of ADJC, upon receipt of an investigative report for allegations of abuse, shall approve or disapprove the report's conclusion that the allegation was substantiated, not resolved or unfounded, or shall order further investigation. Only the Director of ADJC shall have the authority to disapprove a report's conclusion that the allegation of abuse was substantiated. In such cases, the Director must explain the reason for such a decision in writing for personnel reasons. ADJC shall ensure that prompt and appropriate personnel actions are taken in response to substantiated findings.
Status: Substantial Compliance
Discussion: Reviewed this with Director Branham. He described the process and the most recent examples of actions taken.
Recommendation: Provide the Consultant's Committee a listing of reviews and action taken during the next reporting period for continued verification of this process.
Documentation: Discussion with Director Branham at June, 2006 de-briefing. His statement that he reviews all investigations and on average requires additional information on 2-3 investigations per week.
UFN 4.4.12 ADJC shall develop and implement policies and procedures to address management problems that are uncovered during the course of an Investigations and Inspections unit

investigation (e.g., inadequate staffing, location of abuse or fights, etc.). Corrective action plans will be developed to address these problems in an effort to prevent them from reoccurring,

Status: Substantial Compliance

Discussion: Reviewed corrective action plans developed as a result of the QA and I&I process during the July site visit**.** An outline of those improvement plans is contained in UFN 4.4.4.6

Recommendation: Continue to Corrective Action plans from audits with settlement agreement requirements.

Documentation: Corrective action plans for all 3 facilities.

4.5 Disciplinary Confinement/Due Process

UFN 4.5.1 The DOJ acknowledges that the State has enacted policies and procedures regarding the use of exclusion, in-room confinement, lock down, large group, or other such restrictions to ensure usage when strictly appropriate consistent with facility security. The State shall continue to implement those policies and procedures, and shall monitor those policies and procedures for compliance, as described in 4 (c) and 4 (d) above.

Status: Partial Compliance

Discussion:
Exclusion:
In the last report it was shown that the use of exclusion at CMS was very high. The chart from the last report is included as a means of comparison.
January 2006:
AMS ADP 249 #of excls 103 Rate of excls 1.33 Total length in minutes 4917
BCS ADP 84 # of excls 45 Rate of excls 1.73 Total length in minutes 2207
CMS ADP 88 # of excls 142 Rate of excls 5.21 Total length in minutes 6073
ADJC ADP 559 # of exlcs 329 Rate of excls 1.90 Total length in minutes 14,746

June 2006:
AMS ADP 284 # of excls 36 Rate of excls 0.42 Total length in minutes 1,674
BCS ADP 87 # of excls 161 Rate of excls 6.17 Total length in minutes 7,895
CMS ADP 94 # of excls 256 Rate of excls 9.08 Total length in minutes 11,072
ADJC ADP 598 # of excls 512 Rate of excls 2.85 Total length in minutes 23,156

The Arizona Department of Juvenile Corrections (ADJC) defines exclusion as “the brief removal of a juvenile from regular programming and contact with other juveniles.” Exclusion is intended to provide a juvenile with time and space in which to practice appropriate problem solving or a brief cool down period prior to processing

During the last reporting period, the CRIPA Consultants' Committee reviewed the exclusion rates for the month of January 2006, as reflected in Table 1. There was concern that exclusion rates at CMS were considerably high and that "most of the use is self-referred." Since that time, ADJC updated its procedure to allow the MDT, when requested by a juvenile, to permit self-exclusion in the form of quiet time. This is an effort to allow the juvenile to practice self-restraint. Additionally, the juvenile's MDT may also grant the juvenile up to 60 minutes of quiet time away from employees and other juveniles as a reward for good behavior.

The following was provided to the Committee of Consultants by Kellie Warren following the July site visit.

Table 1: Exclusion—January 2006

ADJC Use of Exclusion, January 2006				
Facility	**Average Daily Population**	**# of Exclusions**	**Rate**	**Total Length in Minutes**
AMS	249	103	1.33	4917
BCS	84	45	1.73	2207
CMS	88	142	5.21	6073
ADJC	559	329	1.90	14,746

When compared to the January 2006 rates of exclusion, the March rates (see Table 2) at CMS show a decline. However, the length of time spent in exclusion at CMS has increased. It may be misleading to do month-to-month comparisons, as random monthly fluctuations are not easily explained statistically. Instead, it is better to review several months at a time to get a better indication of trends. Table 3 illustrates the rates of exclusion from March through July 2006 and the following trends were identified.

Table 2: CMS Exclusion—March 2006

CMS Use of Exclusion, March 2006				
Facility	**Average Daily Population**	**# of Exclusions**	**Rate**	**Total Length in Minutes**
CMS	99	157	5.12	6,853

Table 3: Exclusion—March through July 2006

ADJC Use of Exclusion, March Through July 2006				
Month	**# of Exclusions**	**Rate**	**Total Length**	**Average Length**
March	390	2.8	17,764	46

April	297	2.2	13,186	44
May	365	3.1	10,860	31
June	465	3.3	20,641	46
July	374	2.1	17,651	47

Upon further examination, facility rates of exclusion remained low at AMS, while BCS and CMS had periods of higher rates of exclusion during March, May, and June.

Black Canyon School's exclusion rates increased from January to March 2006

TREND ANALYSIS: (This is a summary of the analysis provided by Dr. Warren for this report)

The following explains the trends:
(1)Parole violators returning to BCS
(2)Individual Behavior Plans-Exclusion was utilized as a technique to manage youth behavior.
(3)Implementation of a behavior management practice in Unit Saguaro at CMS.
(4)"ZeroTolerance" to youth disrespecting staff. The practice has been discontinued.
(5)Implementation of ACAB behavior management groups within unit Chiricahua at CMS

Agency Response to trends:
April 24, 2006. The exclusion report was updated to allow youth to self-exclude rather than receive an assigned cool-down period from staff. The management reports need to be adjusted to include categories for self-exclusion & earned exclusion.

Programmatic changes: ADJC loses jurisdiction at age 18. Many youth become disruptive as the 18th birthday approaches. Need to adjust programming to anticipate this issue.

Girls Programming: Being revised to be gender competent, culturally sensitive. Target is early Fall.

Mental Health Services: Classification is being adjusted to better identify youth with MH problems

Behavior Management: Revised behavior management level system. Target is early Fall.

Training: BCS staff are being trained on trauma & gender responsiveness. Also training for all employees on responding to the mentally challenged, emotionally impaired and behaviorally disruptive youth.

P&P 4064 and 4064.01 continue to be required to be followed.
Agency trends showed increases in rates of exclusion in March, then a slight decrease in April, an increase in May and June, and a decrease in July.

In the last report statistics were given on youth assaults at CMS:
CMS January 21
In this report statistics were to be provided on assaults at each facility as a means of comparison. That will be continued in the next reporting period.

Separation
Separation is used by the agency to manage the segregation of juveniles. Placement in separation is seen as a serious and extreme measure and should only be used when all reasonable alternative measures have failed. Juveniles, however, do have an option to self-refer.

Discussion on the use of separation at CMS and AMS showed the process at these two facilities to be consistent with past usage.

During this last reporting period, however, there had been a change in the use of separation at BCS. Individual behavior plans (IBP's) have been developed for youth identified by the treatment teams as those needing identified consequences for their behavior within the facility. These youth are called, at BCS, "frequent fliers", and while the number currently is small the ramifications for the use of exclusion is significant. These youth are given transition planning out of separation that is prior to their placement and may include placement within separation for up to 5 days. The purpose of this type of placement is to be proactive in identifying youth who need intervention due to their past behaviors and to provide sufficient consequences to alter their behavior. There are several issues with this use of separation:
First and foremost: It is a complete change in the previous use of separation. The placement of youth in isolation was viewed as a precursor to acting out and to suicidal behavior. Efforts have been made during the course of the settlement agreement to reduce the use of separation and to release youth from separation in the least amount of time possible. This process increases that usage based on past behavior not on adjustment to the incident that placed them in separation and on any clinical judgment of the directors of separation that their behavior has been modified and they may return to regular programming. Secondly: Due process: There is none. The consequences are determined as part of their "treatment plan" and their placement is based on chronic behavior not the incident that required the use of separation. Hearings are still being held but there does not seem to be a purpose to these hearings since the treatment team has made the decision prior to the hearing.
Third: There is an assumption that increased use of separation will modify behavior. There is nothing in juvenile correctional literature that supports that notion. If, in fact, increased use of separation will modify delinquent behavior then youth would need to be screened for inclusion in this program and only those with a diagnosis consistent with characterological (delinquent) diagnoses should qualify for this program. Youth with depression, suicidal tendencies, etc. would be excluded. Currently that is not happening and if this were included it would present some obvious problems for equity in treatment of youth within the facility.
Fourth: The length of time is excessive. The length of stay in separation will have to increase raising the issues again of the use of separation for exclusion and all of the ramifications of this usage that prompted this intervention by the DOJ.

During the de-briefing held with Director Branham and the leadership team it was

indicated that the transitioning program being developed at BCS would be suspended pending a more thorough examination of the issues raised during the site visit. In a subsequent site visit it was confirmed that the BCS program outlined above was discontinued.

During the June site visit to CMS it was noted that there had been a decline in the use of separation at that facility. It was the opinion of senior staff at CMS that the reason for this was largely the diversion of youth from separation by line staff in the cottages. While this may be appropriate the current policy does not support such diversion. What is necessary is that the referral be made and that a masters level staff review that referral. At AMS it was indicated that youth are being taken to separation due to 10/24's. (Disruption of the facility.) In many cases it was the opinion of senior staff interviewed that youth did not need to be taken to separation nor admitted. Clearly there is a difference in how separation is being used and this needs clarification and consistency across facilities.

The following analysis was supplied by Dr. Kellie Warren:

Referral to Separation

During the last reporting period, the Consultants' Committee reviewed the referral rates to Separation (see Table 4), and included the following time periods from 3/04 to 2/05, 3/05 to 8/05, and 9/05 to 2/06. The categories reviewed included: the total number of referrals to Separation; the total number of self-referrals to Separation; the total number of danger to self referrals to Separation; and the total number of danger to others referrals to Separation.

Table 4: Separation--March 2004 through February 2006

ADJC Separation, March 2004-February 2006						
	3/04 to 2/05		3/05 to 8/05		9/05 to 2/06	
	#	Rate	#	Rate	#	Rate
Total # of Separation referrals	523	2.68	741	3.85	800	4.98
Total # of self-referrals to Separation	149	0.76	217	1.13	264	1.61
Total # of danger to self referrals to Separation	59	0.30	110	0.57	83	0.52
Total # of danger to others referrals to Separation	162	0.83	199	1.03	207	1.29
Average Separation length of stay (hours)	12		10		9	
Average daily population	643		626		564	

In comparison to the last reporting period, from 9/05 to 2/06, the agency has seen a considerable decrease in the number of referrals to Separation (see Table 5).

Table 5: Separation--September 2005 through February 2006 Compared to March 2006 through July 2006

ADJC Separation, 9/05-2/06 Compared to 3/06-7/06				
	# 9/05-2/06	# 3/06-7/06	Rate 9/05-2/06	Rate 3/06-7/06
Total # of Separation referrals	800	782	4.98	4.2
Total # of self-referrals to Separation	264	254	1.61	1.4
Total # of danger to self referrals to Separation	83	73	0.52	0.4
Total # of danger to others referrals to Separation	207	205	1.29	1.1
Average Separation length of stay (hours)	9	9		
Average daily population	564	608		

TREND ANALYSIS: (This analysis provided by Dr. Kellie Warren**)**

As reflected in table 5, ADJC Separation trends show that the referral rate continues to decrease, despite an 8% increase in population. As reflected in table 5, decreases were shown in four categories, including: total number of referrals to separation (from 4.98 to 4.2); total number of self-referrals (from 1.61 to 1.4); total number of danger to self referrals (from 0.52 to 0.4); and total number of danger to others referrals (1.29 to 1.1).

ADJC submits that the following accounts for the decreased use of separation.
Violence Reduction Plan
Culture Norms (ACAB)
New Programming (New Freedom)
Exclusion Policy Revision
In April of 2006, the exclusion policy was revised to allow youth to use exclusion as a reward by earning time in their rooms. This could have been reflected in the decrease in self-referrals to Separation, as many youth historically have used self-referrals for "alone time."

Also, policy now calls for a special staffing after three self-referrals in a month. This procedure could have also had an impact on the decrease in self-referrals as these youth received interventions prior to the trend continuing.

This analysis is consistent with the Committee of Consultants' observations during site visits during the last reporting period as well as discussions with separation staff at each of the facilities during that time period. The use of separation has reduced. Some issues remain and are discussed in 4.5.2, and they will continue to be addressed during the next reporting periods.

Recommendation: Monitor the trends and the agency responses to those trends. Also the

implementation of the new programming for impact on the use of exclusion**.**

Documentation: Discussions with staff during two site visits. Information provided through Youth base as well as a summary provided by Dr. Warren.

UFN 4.5.2 The State shall continue to ensure that youths confined in Separation for more than 24 hours receive a due process hearing by an impartial official to determine whether cause exists for continued confinement.

Status: Substantial Compliance

Discussion: The tables presented in the discussion indicates that approximately 65-75% of the youth placed in separation are returned to regular programming within 4 ½ hrs. This still indicates that between 25 and 35% of the youth are staying longer than 4 ½ hours and around 5% are staying more than 24 hours. In actual numbers 169 youth stayed longer than 24 hours during the last 4 month reporting period reflected in table 7. The issue of due process looks primarily at timeliness of hearings. The question being raised by the Consultant's Committee is the need for separation beyond the 4 ½ hr. threshold that has been established. Also, to what extent the due process provisions need to address this issue. The rating remains at substantial compliance because site visits show the use of separation has reduced and hearings being conducted. In the interest of best practice, however, this question of LOS is raised.

Length of time spent in Separation

In comparison with the last reporting period, and as reflected in Table 5, the average length of stay in Separation remained the same. The Consultants' Committee also examined the length of stay in Separation during the month of January 2006 to include the following categories, as reflected in Table 6:

Table 6: Separation—January 2006 Compared to March 2006

ADJC Separation, January 2006 Compared to March 2006						
Length of Stay (in hours)	**# Jan.**	**# March**	**% Jan.**	**% March**	**Cumulative % Jan.**	**Cumulative % March**
Up to 1 ½	357	346	41	41.2	41	41.2
1 ½ to 2 ½	163	133	19	15.8	60	57.0
2 ½ to 4 ½	109	113	12	13.5	72	70.5
4 ½ to 6 ½	46	41	5	4.9	77	75.4
6 ½ to 8 ½	20	16	2	1.9	79	77.3
8 ½ to 10	6	14	1	1.7	80	78.9
10 to 12	14	21	2	2.5	82	81.4
12 to 14	22	33	3	3.8	85	85.2
14 to 16	22	22	3	2.6	88	87.9

16 to 18	18	18	2	2.1	90	90.0
18 to 20	21	14	2	1.7	92	91.7
20 to 22	23	11	2	1.3	94	93.0
22 to 24	20	18	2	2.1	96	95.1
24+	32	41	4	4.9	100	100.0

As illustrated in Table 6, the average length of stay in Separation decreased from January to March 2006. However, comparing month-to-month rates does not capture the overall trends. When comparing the length of stay in Separation from September 2005 through February 2006 with March 2006 through July 2006 (Table 7), the trend shows a slight increase in Separation lengths of stay over 24 hours.

Table 7: Separation—September 2005 through February 2006 Compared to March 2006 through July 2006

ADJC Separation, 9/05-2/06 Compared to 3/06-7/06						
Length of Stay (in hours)	**# 9/05-2/06**	**# 3/06-7/06**	**% 9/05-2/06**	**% 3/06-7/06**	**Cumulative % 9/05-2/06**	**Cumulative % 3/06-7/06**
Up to 1 ½	1,768	1,124	44.7	35.1	44.7	35.1
1 ½ to 2 ½	551	482	13.9	15.1	58.7	50.2
2 ½ to 4 ½	437	449	11.1	14.0	69.7	64.2
4 ½ to 6 ½	133	163	3.4	5.1	73.1	69.3
6 ½ to 8 ½	98	79	2.5	2.5	75.6	71.8
8 ½ to 10	46	41	1.2	1.3	76.7	73.0
10 to 12	119	125	3.0	3.9	79.7	76.9
12 to 14	154	147	3.9	4.6	83.6	81.5
14 to 16	114	111	2.9	3.5	86.5	85.0
16 to 18	96	75	2.4	2.3	88.9	87.3
18 to 20	84	64	2.1	2.0	91.1	89.3
20 to 22	79	63	2.0	2.0	93.1	91.3
22 to 24	79	109	2.0	3.4	95.1	94.7
24+	195	169	4.9	5.3	100.0	100.0
Total	3,953	3,201	100.0	100.0		

Nearly 70% of youth during both reporting periods spend less than 4 ½ hrs. in separation. In earlier reports the need for expediting hearings was recommended. The issue is whether releases can be expedited. Can the length of time in separation continue to be reduced? Also, during this last reporting period an attempt was made to review files of youth who had remained in separation beyond the 24 hr. period. Time did not allow for a review of those files. That will be done during the next reporting period.
Recommendation: The recommendation is continued from the previous report**:** It is recommended that ADJC utilize the expertise of the separation staff in reviewing its use and developing plans for the continued reduction in the use of separation as well as time in separation especially as it involves self-referrals. Also to track those youth who are spending in excess of 24 hours for review of need for that length of stay.
Documentation: Visits to separation in all three facilities during the reporting periods. Discussions with separation staff in each facility. Review of separation from youth base data system. Review of data provided by Dr. Kellie Warren

5. SPECIAL EDUCATION

UFN 5.1 The State shall at all times, provide all youth confined at the facilities with special education services as required by IDEA, 20 USC sec 1400 et seq., and regulations promulgated thereunder, Section 504 of the Rehabilitation Act of 1973, 29 USC sec 794, and regulations promulgated thereunder, and this agreement.
Status: Substantial Compliance
Discussion: The ADJC education programs at AMS, BCS, and CMS continue to provide special education services consistent with the requirements of IDEA. Several discrepancies related to documentation of service provision were found at one facility during this period. In these instances paperwork had not caught up to practice and youth were receiving appropriate services.
Recommendation: During the third reporting period, the Consultants interviewed teaching staff and youth, and observed classroom instruction at each of the facilities. The Agency maintains compliance with the general provisions in this section.
Documentation: Review of files, monitoring reports, and observations of classes.
UFN 5.2 The State shall retain a Superintendent of Education who shall meet the minimum standards as specified by the State. The State shall provide the Superintendent with sufficient staff and resources to perform the tasks required by this Agreement, [including…]
Status: Substantial Compliance

Discussion: Dr. Judith Lanphar continued in her role as Superintendent of Education during this reporting period. Dr. Lanphar was able to recruit and hire a new business manager during this reporting period. The education management team continues to keep ADJC administrators to continue operation and management of the education program. The on-going support for the education program from Director and Deputy Director of ADJC continues to be critical in ensuring that sufficient staff and resources are available.
Recommendation: No recommendation.
Documentation: Document review, classroom observations, interviews with teachers.
UFN 5.2.1 Oversight of the special education programming in the facilities, including development and implementation of policies and training programs.
Status: Substantial Compliance
Discussion: Dr. Jacobs continues to play an active role in the management of special education service delivery, policy development and review, staff development, and mentoring of new staff.
Recommendation: No recommendation.
Documentation: Discussion with Dr. Jacobs and Deputy Director Gadow; review of policies.
UFN 5.2.2 Monitoring whether special education staffing and resources are sufficient to provide adequate special education services to youth … and to ensure compliance with this agreement;
Status: Substantial Compliance
Discussion: The ADCJ education administration as well as the leadership team of ADJC is sensitive to the challenges associated with providing special education services in juvenile corrections. Discussions with principals at BCS and CMS and with the acting assistant principal at AMS indicated that staff and resources were sufficient. At AMS for example, a new pe/health teacher and a new diagnostician were hired during this reporting period and were completing training. The committee met the new school psychologist serving AMS and BCS who was hired at the end of the previous reporting period. The State continues to offer stipends to special educators in order to attract and retain highly qualified teachers. The ADJC business office is monitoring the adequacy of teacher compensation. The ADJC leadership team understands and appreciates the importance of retaining qualified staff in order to institutionalize the changes that have occurred in the education program during the past two years. For the 2006-07 school year, ADJC developed a school calendar that distributes staff training, intercessions, and school holidays evenly throughout the year. The new calendar allows flexibility and predictability for education staff. Observation of a faculty meeting at AMS and

discussion with a few teachers indicated that in general, education staff morale was high.
Recommendation: The ADJC central administration and the education administration is encouraged to continue to monitor staff and resources.
Documentation: Discussion with teaching staff, education administrators, and classroom observations.
UFN 5.2.3 Development and implementation of a quality assurance program for special education services.
Status: Substantial Compliance
Discussion: The education program continues to use the internal monitoring system developed by Dr. Jacobs to ensure that IEPs and annual reviews are conducted in a timely manner. The Director of Special Education has developed an internal auditing system that has been implemented at each of the facilities.
Recommendation: Drs. Lanphar and Jacobs and Dr. McGlynn, Administrator - Quality Assurance, should jointly develop site visit protocols for Q & A reviews of the special education program and practices at each of the secure facilities.
Documentation: Discussion of quality assurance practices with Drs. Lanphar and Jacobs; review of internal monitoring documents at AMS, BCS, and CMS. Review of Quality Assurance Quarterly Report developed by education staff for the office of quality assurance.
UFN 5.3 The Superintendent shall provide prompt and adequate screening of youth for special education needs and shall identify youth who are receiving special education in their home school districts or who may be eligible to receive special education services but have not been so identified in the past. Such procedures shall include:
Status: Substantial Compliance
Discussion: ADJC education staff continues to interview youth, review prior school records, and examine youths' performance on intake assessments. Students who are not identified during the RAC process at Adobe Mountain School or Black Canyon school as having a history of special education services, may be referred for screening by teaching staff. File review and discussion with staff indicated that while not a common event, youth are referred by teaching staff for screening and possible assessment for special education services. When teachers make referrals, a school based team conducts observations of the student, gathers additional information from students' other teachers, and reviews interventions and instructional strategies and students' responses to those before initiating assessment for special education eligibility.
Recommendation: Continue the process of internal monitoring at each of the three sites covered by the Settlement Agreement.

Documentation: Review of student files and internal monitoring documents; discussion with school psychologist at AMS.
UFN 5.3.1 Guidelines for interviewing youth to determine past receipt of special education services;
Status: Substantial Compliance
Discussion: Intake interviews continue as part of the intake process at RAC for boys at Adobe Mountain School and at RAC at for girls at BCS.
Recommendation: No recommendation.
Documentation: Review of student files, discussion with Dr. Jacobs, ADJC Director of Special Education.
UFN 5.3.2 Protocols developed in conjunction with local school districts and the State Department of Education for expedited reporting of special education status of students entering the facilities, conducting adequate testing of youths' substantive educational knowledge, and performing necessary vision and hearing tests;
Status: Substantial Compliance
Discussion: ADJC education staff continues to confer with the State Department of Education and local school districts concerning reporting of students' special education status and transfer of records for youth entering and exiting ADJC facilities.
Recommendation: Continue regular meetings with ADE, detention centers, and local school districts.
Documentation: Review of students' files, review of internal monitoring documents at AMS, BCS, and CMS.
UFN 5.3.3 Procedures identifying criteria under which staff or teachers must refer a student for evaluation for special education eligibility, including identifying criteria under which youth whose behavior has led to repeated exclusion from class must be referred for evaluation;
Status: Substantial Compliance
Discussion: Practices and criteria for referral of youth for special education eligibility are featured topics in staff development sessions for teachers and other staff. Review of internal monitoring sheets indicate that staff have used the referral process during this reporting period.
Recommendation: Continue to discuss procedures for referring students suspected of having a disability during staff development workshops.

Documentation: Review of child find screening forms, discussions with teachers and principals, review of internal monitoring documents.
UFN 5.3.4 Policies describing the required activities of Student Support Team pre-referral and support team functions;
Status: Substantial Compliance
Discussion: ADJC policies for special education services including the role of the Student Support Team continue in place. At each facility policies related to the student support team are available the school office.
Recommendation: Continue annual training and frequent visits to ADJC schools to monitor and support staff.
Documentation: Review of ADJC Policy 4475. Interviews with special education staff at each facility.
UFN 5.3.5 Policies describing the requirements for comprehensive evaluation procedures to determine eligibility for special education services;
Status: Substantial Compliance
Discussion: Evaluations are completed using criteria developed by the Arizona Department of Education.
Recommendation: No recommendation.
Documentation: Review of policies and directives to staff from Superintendent Lanphar and Special Education Director Jacobs.
UFN 5.3.6 Policies describing the criteria for multidisciplinary team decision-making regarding eligibility for special education.
Status: Substantial Compliance
Discussion: ADJC education staff follow policies for multidisciplinary decision regarding special education eligibility. Review of notes in students' files at AMS, BCS, and CMS revealed that MDT (multidisciplinary team meetings) included special and general education teachers, school psychologists, and supervisors. Decisions made at these meetings reflected a deliberative decision-making process.
Recommendation: No recommendation.
Documentation: Review of students' files at AMS, BCS, and CMS.

UFN 5.4 The State shall continue to ensure that qualified professionals participate in the process for determining special education eligibility as required by federal regulations.
Status: Substantial Compliance
Discussion: Pursuant to Section III.H.5 of the Memorandum of Agreement (MOA), this section of the MOA is terminated from the agreement and no longer subject to monitoring, based upon a finding of "substantial compliance" for at least 18 months.
UFN 5.5 The State shall continue its collaboration with the Arizona Department of Education to ensure appropriate parent guardian or surrogate parent involvement in evaluations, eligibility determinations, placement and provision of special education services.
Status: Substantial Compliance
Discussion: A review of IEPs at each facility revealed that parents and surrogates continue to regularly participate in IEP meetings, evaluations, and eligibility determinations. Thirteen files reviewed contained IEPs developed while students were in ADJC custody. In 9 of those 13 IEP meetings, parents or surrogates participated in person or by phone. In other cases, evidence in the files indicated that parents were contacted but were unable to attend or participate.
Recommendation: Continue to involve parents and surrogates in special education eligibility, evaluation, and IEP meetings.
Documentation: Review of 16 student files.
UFN 5.6 ADJC shall continue to ensure that if a youth is discharged from the facilities before the completion of the educational evaluation required above is complete, ADJC will forward to the superintendent of the youth's receiving school district all information regarding screening and evaluations completed to date, noting what evaluations are yet to be performed.
Status: Substantial Compliance
Discussion: School records clerks continue to track students' METs, IEPs, and scheduled SRBs (Superintendent's Review Board meetings). Receiving school districts receive information about student assessments that are in process. The AZ Department of Education's SAIS (Student Accountability Information System) is used to notify any receiving school district of students' special education status. In addition receiving school districts are notified of students' assessments that are in process. Discussions with the education staff in the central office indicated that there is regular and on-going contact with school districts throughout the state regarding transfer of information and documents about specific students.
Recommendation: No recommendation.
Documentation: Discussion with ADJC central office staff, review of internal special education audits at each facility.

UFN 5.7.1 ADJC shall, in a reasonable time period, create and/or implement an IEP, as defined in 34 C.F.R. § 300 300.340, for each youth who qualifies for an IEP. As part of satisfying this requirement, ADJC shall conduct required evaluations of IEPs, adequately document special education services, and comply with the IDEA regarding parent, surrogate, and student participation in the IEP process. ADJC shall hold team meetings once per week, if necessary, to develop IEPs for qualified special education students in accordance with federal regulations.
Status: Substantial Compliance
Discussion: The Third Semi-annual Report documented substantial improvements in the development and implementation of IEPs. The gains noted earlier have been maintained through the fourth reporting period. Active involvement of Dr. Jacobs in oversight, training, and recruitment of staff has resulted in timely review of students' files and implementation of students' IEPs. Staff appears to be following guidelines developed earlier this year for scheduling MET (multidisciplinary evaluation team) and IEP meetings. The addition of new school psychologists and several new special education teachers, and the continued work of educational diagnosticians at each site have been an important part of sustaining improvement in this area.
Recommendation: Continue on-going staff development and internal auditing of compliance in these requirements.
Documentation: Review of eight students' files and IEPs, and internal audits for AMS, BCS, and CMS.
UFN 5.7.2 In developing or modifying the IEP, ADJC shall ensure that the IEP reflects the individualized education needs of the youth. When the nature or severity of a youth's disability is such that education in regular classes with the use of supplementary aids and services cannot be achieved satisfactorily, ADJC shall provide an appropriate alternate educational setting. ADJC shall ensure that each developed or modified IEP include documentation of the team's consideration of the youth's need for related services and transition planning. ADJC shall employ or contract with appropriate professionals to ensure the timely availability of related services to youths in the facilities.
Status: Substantial Compliance
Discussion: Observations of classes at CMS, interviews with youth at AMS, BCS, and CMS, and discussions with teachers indicate that students' education needs are being met. A review of the internal audits and IEPs at all three sites indicate that related services are being provided by ADJC staff and as needed by contract staff. Plans are underway at all three sites to develop more intensive reading instructional activities for youth enrolled in special education as well as for other youth with low levels of literacy.
Recommendation: No recommendation.
Documentation: Interviews with youth, review of 13 IEPs and related documents, and discussions with teachers, and administrative staff; observation of three treatment team meetings

at AMS.
UFN 5.7.3 The Superintendent shall continue to develop and implement a system to promote parent, guardian, and surrogate involvement in IEP development and placement meetings. This shall include such meetings through telecommunications technology or during times reasonably calculated to accommodate the schedules of parents, guardians, or surrogate parents. ADJC shall post notices in each facility stating the rights of students, parents or guardians regarding education services, including special education services.
Status: Substantial Compliance
Discussion: Review of 13 student IEPs indicated that ADJC education staff continues to appoint surrogates when parents or guardians are unavailable to participate in MET and IEP meetings. Meetings appear to be scheduled at times convenient for parents, guardians, and surrogates. Files revealed instances when parents requested alternate dates and times for meetings other than the dates and times initially suggested by special education staff.[See UFN 5.5 above.]
Recommendation: Continue current practice of involving parents and guardians in IEP meetings; maintain pool of available surrogates when parents or guardians are unavailable to participate.
Documentation: Review of IEP files, discussion with Dr. Gail Jacobs, Special Education Director, ADJC.
UFN 5.7.4 The Superintendent of Education shall develop and implement an education staffing plan to ensure adequate staff to comply with the terms of this agreement. The plan shall provide for…
Status: Substantial Compliance
Discussion: Superintendent Lanphar and her staff appear to be tuned into the staffing requirement of the Settlement Agreement as well as the need to provide sufficient staff to operate an education program that meets the diverse education needs of students it serves.
Recommendation: No recommendation.
Documentation: Review of current vacancies, discussion of recruitment strategies with principals, Dr. Lanphar, and Dr. Jacobs.
UFN 5.7.4.1 Sufficient numbers of certified special education teachers and staff to provide all youths with the opportunity to attend school full-time and to obtain adequate educational services, and to provide teachers with sufficient time to plan lessons, grade assignments, and participate in special education meetings;
Status: Substantial Compliance
Discussion: ADJC continues to recruit special education and other teaching staff on an on-going

basis. The new school schedule for the 2006-07 school year and salaries that are comparable to some school districts in the State will enable ADJC to experience a lower rate of attrition among teaching staff. Teachers appear to have sufficient time to plan lessons, grade materials, and participate in special education meetings. Education staff morale appeared to be high at all three schools covered by the Settlement Agreement.
Recommendation: No recommendation.
Documentation: Interviews with teachers at AMS and CMS, discussion with principals, review of staffing charts.
UFN 5.7.4.2 Sufficient psychological services to provide psychologist participation in the IEPs, administration of psycho-educational assessments, consultation with teachers and staff, and individual counseling related specifically to issues in youths' IEPs and educational plans.
Status: Substantial Compliance
Discussion: The Education Program employs two full-time school psychologists. Contract psychologists are available to assess and provide support to ADJC special education assessment and identification process as needed.
Recommendation: ADJC will have to closely monitor salary schedules for school psychologists to ensure that they are able to retain existing staff for these hard-to-fill positions.
Documentation: Discussion with principals; interview with new school psychologist.
UFN 5.7.5 ADJC will continue to designate an individual at each facility who is responsible for ensuring compliance with all provisions in this Agreement related to special education services .
Status: Substantial Compliance
Discussion: The principals at each facility have been designated as responsible for ensuring compliance with provisions of the Settlement Agreement.
Recommendation: No recommendation.
Documentation: Site visits and discussion with principals at AMS and CMS.
UFN 5.8.1 The State shall ensure that appropriate Section 504 plans are developed for all eligible youth. The State shall employ two Section 504 coordinators/guidance counselors at Adobe Mountain and one such position at each of the other facilities to develop and implement ADJC's Section 504 program and provide additional educational counseling services to youth.
Status: Substantial Compliance
Discussion: At each facility, guidance counselors continue to serve as Section 504 coordinators.

Recommendation: The counselors are encouraged to continue to review students' 504 eligibility and to disseminate information concerning accommodations and supports to the staff.
Documentation: Review of internal audits at each of the ADJC facilities included in the Settlement Agreement.
UFN 5.9.1 The Superintendent of Education shall continue to design and implement annual inservice training requirements for special education staff of not less than four times per year, to enhance their ability to implement their duties under the provisions of this agreement.
Status: Substantial Compliance
Discussion: Pursuant to Section III.H.5 of the Memorandum of Agreement (MOA), this section of the MOA is terminated from the agreement and no longer subject to monitoring, based upon a finding of "substantial compliance" for at least 18 months.
UFN 5.9.2 The Superintendent of Education shall be charged with quality assurance of all special education services at all of the facilities. The Superintendent of Special Education shall, in coordination with the ADJC Quality Assurance Team, develop and implement a written quality assurance program. This program shall include a system of on-going review of at least a representative sample of IEPs developed or modified in the facilities to monitor quality and assure compliance with the requirements of the ADJC policy and the IDEA.
Status: Substantial compliance.
Discussion: Quality assurance monitoring of special education services has taken place at the three facilities included in the Settlement Agreement. As noted above in the discussion of UFN 5.2.3, the education program and the Quality Assurance Team have met to discuss making the quality assurance process and review more efficient and useful to the education program. In general, the internal quality assurance program developed by the education staff is more useful to the operation of the program than practices of the Quality Assurance team. However, over time the review of practices by the QA team should become invaluable outside perspective on special education services.
Recommendation: None.
Documentation: Discussion with Dr. Lanphar, Education Superintendent, and Dr. Gail Jacobs, Director of Special Education. Review of audits for AMS, BCS, and CMS.

6. MEDICAL CARE

UFN 6.1 The state shall ensure that youth in these facilities receive adequate, appropriate and timely (a) Medical, (b) Dental, and (c) Nursing care to meet the individual needs of the youth.

UFN 6.1 (a) Medical

Status (a): Substantial Compliance for Medical Care

Discussion (a): The Consultants Committee reviewed information regarding the need for development of an infectious disease committee. The Consultants Committee met with Dr. Raker on one occasion, Paige Lang, PA, William Jones and April Randle, MD on two occasions.

There have been several changes in the medical staff. Dr. Raker has retired. Mr. Lafond, PA resigned his position as the Physician Assistant at the Catalina School. During the process of this fourth semiannual report, Paige Long, PA, a newly hired physician assistant for the Black Canyon School had resigned. A contract PA, William Jones was hired to work at the Catalina Mountain School. Most of Mr. Jones' experience is in adult corrections. However, he appeared to have a sound foundation.

April Randle, MD has been hired to replace Dr. Raker. Dr. Randle has been systematically going through policies and procedures in an attempt to update and to assist with the process of electronic filing. She is also assisted with medical care both at the Adobe and Black Canyon Schools. They are in the process of interviewing other candidates to replace Paige Long's position or perhaps to take over treatment at the Adobe Mountain School and Dr. Randle will be taking over Paige Long's positions at the Black Canyon School. I suggested that they may want to consider the use of an additional part or full time pediatrician so that if there are any problems in the future that there will be better cross coverage. However, Dr. Randle has been doing an exceptional job in following through with medical care and keeping the program in Substantial Compliance. Among other things, the infectious disease committee is continuing.

Dr. Randle is continuing with consistent weekly supervision of physician extenders, including physician assistants, and if any nurse practitioners will also follow through with them as well.

Brenda Vold, RN-C who is responsible for the medical care at the Black Canyon School facility had previously quit. She was again interviewing for a position at the time of my interviews. I had suggested that the staff review some of the conflict which had developed prior to her leaving initially.

The new medical/infirmary unit at Adobe continues to be functioning well.

The oxygen tanks at all three facilities were full.

Specific protocols and the development of infirmaries at the Black Canyon, Catalina and Adobe Schools have still not been developed. Part of the difficulties with this was at the time of the last interview the only facility which had 24-hour, 7-day per week nursing coverage was the Adobe facility.

In the initial CRIPA investigation there was no immediate concern in the overall care of the youth within these facilities. The Consultants Committee reviewed information regarding the need for development of an infectious disease committee. Dr. Raker informed the Consultants Committee that a committee has been developed. The Consultants Committee has reviewed specific policy regarding this and the formal structure of the committee. The purpose of this committee includes assessing such things as infectious disease issues, immunizations, infectious disease outbreaks, and sexually transmitted disease testing. Currently the infectious disease committee is meeting every two to four weeks.

Recommendations:

1. Continued documentation of the infectious disease committee and ongoing meetings, which address infectious disease issues should continue.
2. There needs to be continued documentation regarding logs and patient discussion notebooks regarding supervision of physician extenders. There should be ongoing consistency with Dr. Randle going to the Catalina School at least once every two weeks, if not weekly, for assessment of the medical facility and supervision of the PA onsite.

Documentation: Interviews with Drs. Raker and Randle, Paige Lang, PA and William Jones, PA reviewing numerous charts, infection disease committee meeting summaries, review of collateral information including the continuous quality improvement program procedures No. 3000.06 and CCHC Essential Standard Y-A-06, page 10. Consent for Medical, Dental, Surgical, Psychiatric and Psychological services procedure No. 3100.22 transportation of juveniles to and from outside referrals. Procedure No. 3100.04 Right to Refuse Health Care. FY 2006 FT allocation summary dated July 18, 2005 Policy 1005.2.03 Quality Assurance Medical Monitoring and Quality Improvements effective 7-15-05. A letter from Dr. Raker to Dean Neitzke dated May 19, 2004 regarding defibrillators was reviewed. Administrative Memorandum #109-06, refusal of health services form, Policy 3040, Procedure 3040.7 and 3040.01, Policy 3090, Procedure 3090.01, Policy 3030, and Procedure 3030.07. All of the documents available for the first semiannual report of March 15, 2005, the second semiannual report and the third semiannual report dated March 15, 2006.

UFN 6.1 (b) Dental

Status (b): Substantial Compliance

Discussion: Deficits in the initial CRIPA evaluation were primarily related to not having a consulting dentist at the Catalina Mountain School. In the initial evaluation, none of the

dentists were reviewed. The Consultants Committee met with William Gillespie, DDS, MHA prior to the second semiannual report. Dr. Gillespie is the dental administrator and has also developed a quality improvement program for dental. He reported that Dr. Brian Sears is the dentist at Adobe and works 40 hours per week. Dr. Gillespie works 20 hours per week at Eagle Point and his other 20 hours is administrative. He reported that Edward Sparks, works 10 hours per week at Catalina, 5 hours per week on Wednesday and 5 hours on Fridays and that Dr. William Gioia works 5 hours twice a week, totaling 10 hours at Black Canyon School. Dr. Gillespie reported that he has a dental database for the last six years. All of the information which Dr. Gillespie previously gave was consistent and supportive of compliancy with the CRIPA agreement. Dr. Gillespie is also responsible for quality assurance.

Dr. Gillespie reported that he has periodic site visits. He reported that they have attempted to follow the ADA requirements regarding general dentistry. He reported that typically the adolescents who are being treated are being treated as adults as their permanent teeth are already in place. He reported that they have once a year evaluations and that every child is evaluated. Dr. Gillespie reported that he continues to attempt to improve the dental services, such as wanting to get a Panorax machine to allow for assessment of breaks and more comprehensive assessment of such issues as root canals. He reported that more recently they have purchased a steam autoclave to work with preventive dentistry. They refer out impacted wisdom teeth. He has hoped to be able to obtain dental hygienists at each of the facilities which will assist with helping with preventative dentistry. Other more complicated issues such as attempting to find a safe way to allow youth to floss has been brought up.

As of the review for the fourth semiannual report, all dentists have remained in place. There were no concerns reported regarding dental positions. I met briefly with Dr. Sears at Adobe who has been working there consistently. He has reported that he has no concerns at Adobe. He showed the Consultants Committee the equipment which he felt was more than satisfactory, including Adobe having a Panorax. The new dental facility is also in the new medical/infirmary building.

In summary, the overall primary area of concern with dental with the initial CRIPA evaluation had to do with there not being a consulting dentist at Catalina. At the present time there is a consulting dentist at Catalina and as such is not an area of acute concern.

Recommendations: 1) The Consultants Committee suggests that Dr. Gillespie continue to work with administration and ADJC to try and assist with improving dental care, including attempting to purchase a Panorax machine for each facility, further work on preventative dentistry with the use of dental hygienists and other areas where he sees a need for improvement. 2) There should be a continued focus in maintaining a full complement of dental staff. 3) Consideration of evaluating youth twice a year should be further discussed.

Documentation: The Consultants Committee reviewed protocols and summaries regarding dental services, interviewed Dr. Gillespie and were shown documentation

regarding consulting dentists at all facilities.
UFN 6.1 (c): Nursing Care
Status (c): Substantial Compliance
Discussion: Implementation of quality assurance has begun for nursing which is consistent in all three facilities. Youth were observed receiving nursing care at all three facilities. Catalina and Black Canyon continue understaffed. They have focused mostly on medication dispersement and more acute medical issues. The Nursing Manager at Black Canyon, Kevin Harper, and the Nursing Manager at Catalina, Karen Eaves, resigned. In addition I interviewed a variety of nurses, including; Brenda Wakefield, RN, Debra Emerick, RN, Sherry Gomez, RN, Daniel Gelli, LPN, Pam Vetsch, RN and others. Kevin Harper was replaced by Dawn Grasso, RN, Rick Bianci, RN is now the nursing supervisor at Catalina. There has been improvement in security; most of the time on the day shift security is in nursing when youth are being assessed. Catalina has again filled their position for a nurse manager. Quality assurance has continued at Catalina, Adobe and Black Canyon Schools. The Consultants Committee reviewed 10 examples of reviewed QA reviews from all three facilities. Mr. Bianci has bought some reference books at Catalina out of specialized funds. There is a new PDR at Black Canyon. There are no new reference books at Adobe. It is reported that the nurses will have access to Internet information. However, when speaking with three or four of the nurses, none of them had knowledge of how to retrieve this data and none of them had actually done it. There was no inservice that was held regarding any kind of computerized reference material.
Recommendations: 1) All attempts should continue to be made to have a full staffing of nurses. 2) Continued implementation of quality assurance will continue to be assessed. 3) There should be updated nursing reference books.
Documentation: Nursing staff including Dawn Grasso, RN, from Black Canyon, Mr. Bianci, the new nurse manager at the Catalina School and the nurse manager from Adobe Mountain School were all interviewed. Prior documentation from the third semi-annual report was reviewed. Charts were reviewed, the nursing receiving screening form was reviewed, and the quality assurance forms were reviewed.
UFN 6.2. The state shall ensure there is a sufficient number of adequately trained nursing staff on all shifts to provide medical and nursing care to youth as needed. If, despite the states good faith effort to recruit and retain nursing staff, nursing shortages significantly impedes substantial compliance with the paragraph, the state may utilize a sufficient number of adequately trained paramedics, as necessary, to provide medical coverage during the overnight shifts at the facilities.

Status: Partial Compliance

Discussion: There has been a significant successful effort to hire new staff. Mr. Bianci, the nursing supervisor at Catalina informed the Consultants Committee that they are currently "down" five positions. The Consultants Committee met with Dawn Grasso, RN, nurse supervisor at Black Canyon. Mrs. Grasso reported that there are not enough nursing positions for overnight coverage. The nurse supervisor at Adobe reported that their nursing positions are filled. Overall, they were quite satisfied with this. All three facilities had budgeted nighttime positions so that there should be 24-hour, 7 days a week nursing at each facility. The process of structuring infirmaries at the other facilities is still in discussion.

At present, the concept of whether there will be one central infirmary or in the Consultant Committees opinion, an infirmary at each institution is still in discussion. However, the infirmary is in place at Adobe.

At Adobe a new medical/nursing building is being constructed which physically can house an infirmary. The Black Canyon and Catalina facilities hae space which can be used as an infirmary. As such, minimal, if any, additional structural changes would be needed.

Infirmary care requires 24 hour nursing. Admission to or discharge from an infirmary requires a physician's order. Health records for the youth should be easily accessible. Infirmary care requires minimally daily monitoring. Infirmaries are designed for those youth requiring skilled nursing care and those who cannot be medically managed safely in the cottages.

Approved nursing positions will allow for 24-hour, 7-day a week nursing coverage at all three institutions. Adobe Mountain School has established its 24-hour nursing, 7 days per week. Black Canyon and Catalina are hoping to soon have 24-hour, 7 days per week nursing as well. Once this is accomplished, further discussion regarding infirmaries at the other institutions will be discussed. Safety issues regarding the transfer of youth to the medical unit has improved. On the day shift at all three facilities, more often than not, security is available and with the youth when they are in the medical facility. All of the nurses which the Consultants Committee spoke with felt that this was a vast improvement and offered a level of safety for them. They continue to acknowledge that later in the day, there is no security. However, they reported that there are far fewer youth who come to nursing during that time and when possible they will try to see the youth in the dorm. The Consultants Committee would expect at this point that there would be 24 hour, 7 days per week nursing.

There are no policies in place or procedures observed where nurses attempt to explain to the youth the potential side effects of the medication or review with the youth regarding issues of side effects.

Recommendations: 1) Continued efforts should be made to fill any open nursing hours.

2) The Consultants Committee recommends an infirmary at each facility so that adequate medical care can be provided. At present, staffing 24-hour nursing has reportedly been put into place. However, positions remain open. The justification for 24-hour nursing includes the care of children who are sicklier, the care of children with infectious disease, the care of children who have just recently returned from the hospital who may have significant medical needs, external fixaters or other medical issues which should be handled by nurses. In addition, there is also the possibility that a child will be placed in restraint on the night shift. A nurse should be present for that as well.

Documentation: Interviews with the nurse supervisors at Black Canyon, Adobe and Catalina Mountain School. Interviews with Dr. Kellie Warren, Dr. Seymour, and Dianne Gadow. Reviewing the nursing quality assurance review, a 2-page, 22-item review, review of QA reviews, chart notes, a review of charts, procedure 3000.08, organization of health records policy, a medical summary sheet and other medical record related sheets, including a SOAP note, an ambulatory healthcare report. Policies reviewed included 3000.01, 3000.05, 3000.06, 3000.15, 3000.16, 3100.05 3100.09, 3100.12 and 3100.26.

UFN 6.3 The state shall continue to implement a nursing quality assurance process, including audits of medical charts, and medication administration records to monitor nursing assessments, care and documentation where problematic, trends are identified, the state shall timely develop, implement and monitor a corrective action plan.

Status: Substantial Compliance

Discussion: As described in UFN 6.2 discussion, a 22-item quality assurance review is being used at all three facilities for nursing. Based on discussion with all three supervisory nurses reviewing charts which were being assessed by this process. However, the amount of time that this has been occurring is unclear. All three supervisory nurses reported that they have been pulling out 10 charts per month which have been undergoing the quality assurance process. The Consultants Committee has been informed by all three nurses that this has been working consistently and has been helpful. All three facilities have done this consistently since December of 2005. There are quarterly QA meetings to continue assessing Quality Assurance.

The Consultants Committee has reviewed the process of how problematic trends are identified or how the state will develop in a timely way, implement and monitor a corrective action plan. Policies and initial protocols are being implemented at all three facilities. Initially, the staff reported that they were beginning talks with the National Commission on Correctional Health Care. At present, the Consultants Committee was informed that ADJC will not formally work with the National Commission until all policies are in place.

Recommendations: 1) The policies and procedures regarding quality assurance for nursing needs to be followed in a consistent pattern. 2) When problematic trends are identified, continued verification of how timely implementation and monitoring of a corrective plan should continue. 3) Follow up with the NCCHC as was stated to the

Consultants Committee initially would occur is expected to occur.

Documentation: Interviews included Dr. Warren, Dr. Seymour, Dr. Randle, all three supervisory nurses, and Dr. Megan McGlynn. Documents reviewed included the new quality assurance form for nursing, relevant policies including 3100.17 and youth charts, QA policy and procedures. The CRIPA UFN 6.3 Action Plan transmittal form was reviewed.

UFN 6.4 The state shall develop and implement a formal system for the pharmacist to document alerts to the physicians regarding information about any youth's medication issues.

Status: Substantial Compliance

Discussion: Pursuant to Section III.H.5 of the Memorandum of Agreement (MOA), this section of the MOA is terminated from the agreement and no longer subject to monitoring, based upon a finding of "substantial compliance" for at least 18 months.

7. MENTAL HEALTH CARE

UFN 7.1 The state shall ensure that adequate mental health care and treatment services are provided to youth in the facilities.

Status: Partial Compliance

Discussion: A mental health outline has been developed. The discussion within these outlines will be referred to in the remaining components of Section 7.

I. Initial Intake Screening:

A. Timely medical care to meet the individuals needs. The majority of intake screening is done through the RAC unit at the Adobe Mountain School. The initial screening is done in a timely fashion (within one hour) of the youth arriving to the facility they are given several initial intake screenings, including the Criminogenic and Protective Factors Assessment (CAPFA). One hundred percent of youth coming into the institution are given this assessment. In addition, they are given the MAYSI and the SASSI (for substance abuse issues). At the present time, 96 percent of the children at the facility have a history of substance use and as such, everybody is receiving a SASSI. A Wechsler Intelligence Scale for Children, Fourth Edition (WISC-IV) and a Woodcock Johnson to further assess educational needs will be performed at the initial assessment through education. At the present time, there are two psych associates assisting with the evaluations in the RAC program, Paul Bosse and Kenneth McNichols and a supervising psychologist. One is from the Enterprise Dorm and the other from the Challenger Dorm. RAC is still waiting for two new psych associates to assist with this process. Mr. Bosse and Mr. McNichols reported that the interview process takes about four hours. They reported prior to the second annual

report that they were not clear regarding referrals for cognitive testing and reported this is occurring.

At the present time, for those youth who have not had intelligence testing or achievement testing within the past year, this is reportedly now being completed at the time of intake at RAC. Dr. Seymour reported that Dr. Samaretti, the supervising psychologist at RAC is continuing to work in developing and integrating the complexities the assessment process at RAC. In addition, the MAYSI is being completed and the facility has contacted the University of Massachusetts. The other complexities of RAC including completion of the CAPFA, SASSI and other assessments are being completed consistently, allowing youth with particular mental health issues to be identified. The achievement tests and cognitive testing has been changed without a written understanding. The currently used testing is adequate but less ideal than using the WISC-IV and Woodcock-Johnson.

Tom Seymour, Ph. D., has been placed in charge of mental health services. Dr. Seymour and Dr. Gold previously reviewed components of the CAPFA with me. Dr. Gold has now resigned. Her position is still open. The four most relevant areas of the CAPFA include the behavioral health domain, the psychiatric aggression domain, the attitude and behavior domain and the alcohol and drug domain. At the present time, the psychologist signs off on the behavioral health domain, but the psych associate signs off on the other three. If a particular medical issue is identified the youth is referred to pediatrician for further followup. Based on my discussions with the pediatrician and the review of a number of charts, this has appeared to occur in a timely and efficient manner.

B. Screening Tools and Processes

- **Identification of Suicidal youth** – Initial identification of suicide youth will be through an initial interview which will include giving of the CAPFA and MAYSI assessments.
- **Identification of Youth with Substance Abuse Problems** – 96 percent of youth entering Arizona Department of Juvenile Corrections have a history of substance abuse use. As such, basically all the children are considered to have substance abuse problems. Nonetheless, as part of the initial intake, the children are given the SASSI. This is a validated assessment to further address potential substance abuse issues. One of the identified difficulties at the present time is that each facility has only one cottage, which focuses on substance abuse and even within these facilities there have been prior mental health staffing shortages. As such, although many of the youth have been identified with a history of substance abuse, interventions have not been consistently been put into place.
- There have been a variety of additional new staff hired that have substance abuse treatment background. Now each psych associate in charge of special treatment units, are all LISAC certified, except one who is a licensed clinical social worker with a significant amount of prior substance abuse treatment history. In addition, a supervisor for all of substance abuse for the Arizona Department of Juvenile Corrections has been hired. In addition to the specialized treatment programs, the New Freedom Program will encompass a significant component of substance abuse treatment. There is still a process which needs to be in place regarding how children of more significant need are identified versus others.

- **Identification of Youth with Cognitive and Learning Disorders** – The Consultants Committee was informed by Dianne Gadow that the plan on the initial assessment within the RAC unit will be to have a representative from education give all youth the Wechsler Intelligence Scale for Children, Fourth Edition (WISC-IV) to assess cognition. At present, the plan will be to implement the WASI for youth who have not had intelligence testing over the past year, to further assess achievement (mathematics, reading and written expression). Youth will be given the Woodcock Johnson test of achievement. At the present time different testing instruments are being used. These materials take less time and are less ideal, but sufficient.
- **Identification of Youth Taking Psychotropic Medication or Otherwise Needing Referral to Psychiatry** - The behavioral health domain of the CAPFA is signed off by the psychologist. A decision regarding referral recommendations is reportedly made at that time. In speaking with both psychiatrists at Adobe, as well as the treating psychiatrist at the Black Canyon School, Dr. Diebler, and in reviewing numerous charts, followup on referrals occur in a timely fashion, essentially seeing the youth the next time they are in the facility. Additional mental health screening to assist with the referrals include the MAYSI and SASSI. There is a plan to revise the mental health referral policy, both to psychologists and psychiatrists for those youth that are exhibiting mental health problems, but do not yet have current mental health diagnoses or are not yet on medications. This policy and planned summary are not yet in place, based on the information reviewed. Those youth who are currently taking psychotropic medications are referred in a timely manner to psychiatry. Policies include 3100.01, 14203.04, Mental Health Referral Form 4203.00, Draft Behavioral Health Screening and Assessment, 4203.02, 4321.02, 4321.01 referrals were reviewed.
- **Identification of Youth with Other Behavioral, Educational, and Mental Health Needs** – Initial identification will occur at the RAC screening in association with a clinical interview with implementation of the CAPFA, MAYSI and SASSI assessment. There will be four psych associates and one psychologist within the RAC unit. They now have a full complement of staff.

C . Staffing and Training/Qualifications of Staff Conducting Screening:

There have been significant amounts of training. Staff has had CAPFA classroom training with clear identification of those individuals who have had the four-hour CAPFA followup training. Prior to the third semiannual report, 198 individuals completed the initial CAPFA assessment and 185 individuals did the four-hour CAPFA followup. There has been a significant focus on staff training and reassessing staff qualifications regarding those conducting screenings. There has now been significant training regarding the new comprehensive treatment program, New Freedom.

II. Timely Referrals for Mental Health and Psychiatric Assessment Post-Intake

UFN 7.33, 7.331, 7.332, 7.333, 7.3.3.4: The action plan is to revise mental health referral policy for those youth on psychotropic medication. The process should ensure that juveniles on psychotropic medication receive adequate psychiatric followup. Specific policies regarding timely referrals and the process of these timely referrals regarding communication between a qualified mental health professional and the psychiatrist or an initial evaluator and either mental health or psychiatrist still remain somewhat vague. Based on my discussions with the psych

associates, psychologists and psychiatrists, the referrals are being made in a timely manner but there is no specific policy which treaters are following. In assessing mental health charts, youth are consistently seen in a timely manner.

Now, through the new freedom assessment protocols, there will be a rating system for youth dependant on the severity of their mental health presentation. This will then be correlated to the level of treatment youth will receive. According to interviews with Drs. Seymour and Warren, this new assessment protocol has not yet been implemented but plans are that it will begin shortly. This will be reviewed closely for the fifth semiannual report.

III. Assessments:

A. Psychiatric: Psychiatric assessments should occur in a timely manner. There are procedures regarding the timeframe when a youth initially comes to the institution on psychotropic medications and when they are seen by the psychiatrist. Assuming that they are not unstable, 48 to 72 hours appears reasonable. There are now procedures 7.3.3.1-7.3.3.4, regarding referral to a psychiatrist for a youth with acute or chronic mental health issues who may not be on psychotropic medications. The psychiatric assessment should include review of collateral information, discussion with the psych associate or psychologist involved in treatment for the youth for clarification of the referral question. Significant attempts at communication with the family regarding the psychiatric history, requests for psychiatric material including prior discharge summaries and psychiatric or psychological assessments if they are not part of the youth's file. The Academy of Child and Adolescent Psychiatry recommends two hours for a comprehensive psychiatric assessment. This is variable, depending on the child.

The customary amount of time for a new assessment is typically at least one and a half hours, plus the additional time needed for collateral contacts and review of collateral information. The Consultants Committee would recommend a clear structure to the psychiatric assessments following a biopsychosocial framework with a focus on the acute behavioral issues, psychiatric diagnoses, and treatment plan with clear goals. Informed consent must be obtained. Documentation of Informed Consent must be on the chart. Clear goals of treatment, side effects of any psychotropic medications need to be documented, either in the material sent to the parent or specific documentation if one so chooses. The Consultants Committee would recommend that initial psychiatric assessments be typed so as to assist with the ability to read them and so they can be more easily used in treatment planning meetings, hospitalizations, transition meetings, etc. Overall, psychiatric assessment at all three facilities has been consistent and comprehensive. There is a need for better attempts and follow through with collateral contacts and development of clear procedures for obtaining informed consent.

B. Psychological/Psych Associate: The psychologist and psych associates who are completing initial assessments on youth need to use the information available through CAPFA, the MAYSI, and SASSI assessments for their initial assessments. They need to review available collateral information and conduct a comprehensive clinical evaluation with a defined mental status exam, preliminary diagnoses, and recommendation for treatment, referrals, and treatment goals.

C. Substance Abuse: Initial substance abuse assessments should be completed through the RAC. This will be initially completed through implementation of the MAYSI and SASSI assessments. At the present time, the Consultants Committee has been informed that 96 percent of the youth at the Arizona Department of Juvenile Corrections have a history of substance use and are in need of treatment on some level. The Consultants Committee would strongly recommend that the psychologist at the RAC and Mr. Grasso assess this particular issue and make a determination of the treatment plan for each child regarding alcohol and substance abuse. This process was begun but has not been consistent or formalized. It is developing as the new Freedom program is developing. Dr. Seymour reported that there are three key reasons for referrals of youth to the special treatment substance abuse programs (RSAT). This can include: 1) via court order, 2) a clear identification of an alcohol or substance abuse dependency versus abuse, and 3) any child who comes in that has a history of med amphetamine or other potentially acute life-threatening abuse. In addition, Dr. Seymour and Dr. Warren reported that the New Freedom Program will comprehensively address substance abuse issues, including the use of a treatment focused workbook and the use of process groups. At present, clear identification of those children in most acute need is still in process.

D. Cognitive: As was described in our prior meeting with Ms. Gadow and others, cognitive assessment will occur at the RAC through education. This will include all youth who have not had testing in the past year, being given cognitive and an achievement test to assess educational achievement. This will be a tremendous accomplishment when consistently achieved.

E. Suicide Risk Assessments: Initial suicide risk assessments through the RAC will be accomplished through clinical interview and assessment of the CAPFA, MAYSI and suicide probability scale. Newly hired direct care medical and mental health staff will receive additional training on suicide prevention to assist with effective intervention and identification of youth who are suicidal.

F. Emergency Mental Health Assessments (e.g., sexual assault, acute loss, suicidal threat, etc.) Regarding issues of physical or sexual assault there will be an obvious medical assessment as per ADJC policy, such as Policy No. 3100.18 (alleged sexual assault within a secure facility). This includes a facility psychologist being available to evaluate the juvenile for a mental status examination. 1) At the present time, based on the information reviewed and discussion with staff, there is no consistent clear mental health assessment in place. 2) Other than the psychologists or their designee seeing an acute sexual assault victim, there are no additional descriptions regarding the role of the evaluation. In the Consultants Committee opinion, psychiatry should also be involved with that assessment. 3) There is no clear policy regarding enforced medication at times a psychiatric emergency.

In addition to a psych associate or psychologist taking a clear history, there needs to be clear policy regarding the examination and documentation to the extent of physical injury by the pediatrician and a clear determination whether or not a referral to a medical facility is indicated. With the victim's consent, the examination includes the collection of evidence from the victim, using a kit approved by the local legal authority. Prophylactic equipment, including emergency contraception consistent with the state law, the regulations of the jurisdiction of followup care for sexually transmitted or other communicable diseases are offered to all victims as appropriate. A report is made to the correctional authorities to

effect a separation of the victim from his/her assailant in the housing assignments. Assessment of the adolescent victim for potential for suicide and/or anxiety disorders or other mental health problems is completed. Treatment plans must also take into understanding the cultural competency and language issues.

IV. Comprehensive Treatment Planning:

A – B: Interdisciplinary Plan Content (Specific content requirements identified in UFN 7.3.6.1; 7.3.6.1-9.). **C) Cultural competency and language considerations. D) Transition to the community.** (Psychiatry, psychology/psych associates, medical, education, social work). Treatment plans have specific content which need to include: the treatment plan to be individualized (7.3.6.1), the identification of the mental and/or behavioral health issues to be addressed, a description of any medication or medical course of action to be pursued (7.3.6.2, including the initiation of psychotropic medication (7.3.6.3), a description of planned activities (interventions to monitor the efficacy of any medication or the possibility of side effects) (7.3.6.4), a description of any medical behavior plan or strategies to be undertaken (7.3.6.5), a description of any counseling or psychotherapy to be provided (7.3.6.6), a determination of whether the type of level of treatment needed can be provided in the youth's current placement (7.3.6.7), a plan for monitoring the course of treatment (7.3.6.8). and development of a transition plan for when the youth leaves the care of the state, which shall include providing the youth and his/her parents/guardian with information regarding mental health resources available in the youth's home community; making referrals to such services when appropriate; and providing assistance in making initial appointments with service providers (7.3.6.9).

Policies regarding interdisciplinary treatment planning have been put into place starting 4-25-05. According to Dr. Seymour, case plans are now being implemented at near 100% based on report. They are being reassessed on 30, 60, and 90 day intervals. The Consultants Committee reviewed treatment plans from all three facilities. The complexities of everything that has gone into these treatment plans are quite impressive. However, attendance by all staff are still variable. Apparently Dr. Diebler is the only psychiatrist who has been attending treatment plan meetings. However, he has not attended them consistently. The treatment plans are quite complex and at present, a great beginning. As time progresses, using the information at hand to develop well-structured plans regarding education, mental health, behavioral interventions and transitions to the community should be an ultimate goal. The current plans are clearly going in that direction.

There are now additional attempts at cultural competency, including a Spanish speaking therapist to assist with Spanish speaking groups and a liaison, Frances Gonzalez, to assist with native cultural competency for native Americans and transitions back to reservations. There are interpreters available for Spanish speaking families and youth in each of the facilities. There is a relative paucity of culturally competent and bilingual therapists. There is no Spanish speaking licensed therapist at the Catalina Mountain School. Mental health treatment for Spanish speaking youth at this facility is still completed by a nonmental health employee. Policies for appropriate treatment plans are in place. They have begun to be implemented.

V. Mental Health Treatment

A. Counseling/Therapy services:

Prior to the Third Semiannual Report there were significant concerns over staffing issues. At the time of this report, most psych associate positions were filled. Dr. Peta is now working half time and this position needs to be filled. In addition, the psychology position at Catalina needs to be filled. Until all positions are filled, mental health interventions will have some level of compromise. This decreases the likelihood of youth being seen consistently who are in need of therapeutic treatment. New forms to assess how many youth are being seen by individual psych associates have been developed. There is a nearly full complement of psych associates and psychologists at the facilities seeing youth relatively consistently. At the present time, the facilities are changing over to the New Freedom plan, the process of how youth are treated will change. For example, youth will not be treated cottage by cottage, but rather by need. As such, the issue of consistency in treatment and followup and identification of children with needs and how they are treated will be more comprehensively assessed during the process of the next semiannual report. The psych associates and psychologists interviewed appeared confident to complete the roles defined. Treatment should be consistent with what is determined within the treatment plan and the needs of the youth.

Goals and measurements of success need to be developed regarding target symptoms and assessment of these symptoms following set periods of time. There will now be 30, 60, and 90-day assessments.

B. Substance abuse treatment services: Each facility has one substance abuse treatment unit. These units have not been consistently staffed with at least one psych associate who has certification in substance abuse treatment. The Consultants Committee was informed that the substance abuse treatment units now have LISAC certified psych associates in Catalina and Black Canyon. At Adobe, they have an LSCW with substance abuse treatment background.

The development of the New Freedom Program will hopefully better address the significant alcohol and substance abuse and dependency issues.

C. Behavioral intervention staffing and training/qualifications of staff providing counseling/therapy services: There is now less of a blurring between mental health interventions and nonmental health interventions. The great majority of mental health interventions are by trained and licensed mental health professionals. There are some exceptions where some bachelor level YPO-3's are assisting or directly involved with mental health treatment. This isn't a relatively well structured process. The behavioral intervention plan is still in the process of being completed.

Mental health interventions regarding behavioral management will include more complicated behavioral interventions with the youth, often in association with dynamic and other cognitive approaches. Therapeutic groups should be run by a qualified mental health professional such as a psych associate, psychologist or a psychiatrist. If one had advanced practice nurses they would also be included in that group. At the present time, likely due to

the deficit in psych associates and psychology positions, it is important to clearly demarcate the role or mental health and the role of non-mental health staff. Non-mental health staff should not be responsible in either solely leading groups or direct mental health interventions.

VI. Psychotropic medication management:

A. Appropriateness of prescribed medications and dosages: Charts were reviewed from all of the prescribing psychiatrists. In the Consultants Committees opinion, prescribed medication and dosages were appropriate for the symptoms being treated.

B. Monitoring of medications being administered:

a. Lab work protocols: There are new draft procedures regarding lab work protocols. These are in the process of being followed by all of the treating psychiatrists. Overall, I saw no deficits regarding lab works being ordered for the medications which youth were on. This will be reassessed.

b. Side effect monitoring (e.g., AIMS): Side effect monitoring has primarily been focused on clinical assessment of side effects for example assessing whether there are extrapyramidal side effect or signs of tardive dyskenesia. Overall, it is the opinion of the Consultants Committee that there has been appropriate assessment of these. However, the Consultants Committee suggests that this could be more clearly documented. In addition, using standardized assessments such as the AIMS would be of assistance with this.

C. Documentation/charting: The Consultants Committee reviewed charting from all current psychiatrists within the Arizona Department of Juvenile Corrections. Overall, charting was readable and consistent; signatures were legible. When collateral information was used this was substantiated in the chart. There was inconsistency regarding the initial psychiatric assessment and its placement in the charts. For some, they were handwritten and for others they had been typed by the psychiatrist, or they had access to a transcriber. The Consultants Committee would recommend that the initial assessment be typed and comprehensive as has previously been described in this outline.

D. Informed consent: The Consultants Committee reviewed charts from all of the current psychiatrists. The psychiatrists reported that they make attempts to reach parents or guardians regarding informed consent and then document this. There was some documentation that attempts were made. More often than not when documentation that informed consent was obtained, there was no clarification of what specifically was reviewed with the parents regarding goals and side effects of the medication. More often than not when an informed consent couldn't be obtained by the physician it was given to the nurse to obtain the informed consent. None of the nurses interviewed at any of the three facilities could review specific goals and side effects of psychotropic medications. Only nurses at Catalina had specific updated child and adolescent psychopharmacology reference books to assist them with this process. The facilities now have a spiral bound book on psychotropic consents entitled "A Resource Book of Medication Information Handouts".

It is the opinion of the Consultants Committee that most of the parents had likely been contacted on some level. However, based on the review of charts, the information reviewed with the parents regarding goals and side effects remains deficient. The Consultants Committee view is that this will now be improved upon with the side effect handouts for

parents, youth and teachers. Policy regarding psychotropic medication, Informed Consent, and procedure 3025.01 was reviewed. Now that the specific policy is in place, the consultants committee was informed that the handouts will be given to youth and parents to assist with informed consent. This will be looked at closely for the fifth semiannual report.

E. Staffing and training/qualifications of psychiatric staff: Clear informed consent needs to be given both to the youth and his guardian. The specific information given and what was reviewed should be documented. If a particular handout were given, documentation regarding what handout was given and how it was explained should be recorded.

Previously when the Consultants Committee was interviewing, the goal was to increase psychiatric services at the Catalina program from .5 to 1.0 FTE. It was now decided that it would remain a .5 FTE and a 1.0 FTE psychiatric physician at the Black Canyon. Dr. Diebler, an adult trained psychiatrist was hired. He works .75 FTE at Black Canyon and works .25 FTE at the Adobe Mountain School to replace the .5 FTE psychiatry position which was vacated in their special treatment unit.

Minimally, psychiatrists should be board certified in adult psychiatry with significant experience in treating adolescents. The Consultants Committee would recommend that within ADJC that there is at least one board certified child and adolescent psychiatrist. At the present time, there is one .5 FTE child and adolescent psychiatrist who is not board certified.

VII. Crisis Management:

A. Use of restraints: Based on the Consultants Committee interviews at all three facilities, restraints are used more than they have in the past. This is potentially due to staff turnover, potentially the mix of youth who are coming to the facilities (that they are more significantly mentally ill), or perhaps some other reason.

The Consultants Committee understands that nursing coverage at some point will provide 24 hours per day. As such, nursing should be assessing vitals and assessing the youth once they have been placed in restraints every 15 minutes for any morbidity. It is unclear whether this is occurring.

It is extremely important that the restraint policy and procedures be reviewed. The purpose of mental health restraints is therapeutic. There is a clearly defined difference between the use of security restraints and mental health restraints. This needs to be identified and implemented.

It is best when the psychiatrist can be contacted prior to the youth being placed in restraint. When they are placed in restraint it would be the Consultants Committee's recommendations that the psychiatrist is contacted within one hour and are able to assess the child within two hours if they are still in restraints. Specific national protocols continue to be variable. Many hospital settings and states still require a one-hour rule (where a physician has to evaluate a child in restraint within one hour). Due to the difficulty of independent hospitals being able to follow through with this and the cost for on call

psychiatrists, many hospitals use their emergency room physician or other physicians who may be on call for that initial assessment. Any MD can initially assess the child. Ideally it should be a psychiatrist. At present, the Consultants Committee has been informed that each facility has at least one psychiatrist on call and has been given a state phone for that purpose.

All staff using restraints on youth has reportedly had TCI training. It is important that this remains 100% consistent. There has been much discussion regarding the use of supine four-point restraint, versus a sitting restraint. After review of available literature, it is the opinion of the Consultants Committee that there is no identified significant difference in morbidity or mortality in the chair versus a supine restraint.

Restraints should never be used for behavioral control. In the rare instance when a juvenile would be restrained beyond one hour, exercising each limb for at least 10 minutes every 2 hours is recommended to prevent blood clots.

There must be performance measures which include no new injuries, comparison of the previous year, expressed number of occurrences, trends in these occurrences, and ultimate outcomes. The National Commission of Correctional Health Care recommends that every 15 minutes a health trained personnel health service staff check any patient placed in clinically ordered restraints and that the checks are documented. Fifteen minute checks have not occurred consistently. Clear assessment of restraint and development of appropriate mental health policy must occur.

If a restrained juvenile has any medical or mental health condition a physician must be contacted ASAP.

B. Separation/Exclusion: The NCCHC definition of a segregated juvenile are those isolated from the general population and who receive services and activities apart from other juveniles. Youth whether in separation or exclusion fall into this category. The Consultants Committee has a concern that youth that are placed on separation or exclusion on multiple occasions will have a higher likelihood of having underlying mental health issues and being at higher risk for a suicide attempt. The use of segregation as a cottage management tool is termed exclusion. During the process of this assessment, there is no clear documentation of youth who have been repeatedly placed on exclusion, although attempts to obtain this material were made during the evaluation process. The Consultant's Committee concerns were that if youth on exclusion were to have concerning or potentially suicidal behavior, there was no procedure for when staff should contact mental health. The Consultants Committee would recommend that a list of basic concerning/suicidal-type behaviors should be part of the dorm staff lists which is used to assess the youth on exclusion and if any of these items are identified, mental health should be contacted.

Obviously, youth that are placed on separation (placement onto the separation unit)for mental health issues will have more intensive mental health assessment during this process. Youth who are placed on separation are consistently seen by the MHTC on the separation unit.

If for any reason, out of control behavior lasts for more than 24-hours the youth must be evaluated by a psych associate, psychologist or psychiatrist. This does not consistently occur.

There were inconsistencies regarding youths placed on separation. The Consultants Committee understood why this was needed due to potential staffing and risk issues in the evening. The Consultants Committee would recommend that there be clarification and potential policy/procedure regarding when a youth who is potentially on a level II crisis, may spend the day or other youth on crisis may spend the day in the cottage but the evenings in separation. At present, there is no MHTC for separation at Adobe or Catalina.

The Consultants Committee also expressed some level of concern regarding youth who are in the separation unit. In particular when there are acute or concerning mental health issues, at what point does staff call for psychological and/or psychiatric assessments. As a reminder, youth Rivera who was in the process of putting staples under his skin and refusing medications during the October 2005 assessment was the same youth who had been assessed at Catalina, in the second semiannual report, awaiting hospitalization.

Policy No. 4064 regarding security exclusion describes issues of removal and exclusion and concern over issues such as suicide prevention.

C. Psychiatric Assessment of Youth:

a. Timeliness:
b. Assessment:
c. Followup care

The terminology, psychiatric hospitalization, implies that a psychiatrist needs to be involved with this process. Psychiatric hospitalization should occur in a timely fashion. When a youth is identified as needing hospitalization every attempt should be made within a 24-hour period. At the present time, there are still delays in hospitalization, but it has overall occurred between 24 and 72 hours. At present youth are typically hospitalized at a private hospital and then transferred to a public hospital. On two of the youth, hospitalization has taken up to a week if not longer. This is not efficient or safe. When one thinks about the issue of safety it is not just regarding suicide risk, but also morbidity such as cutting, head banging, etc.

The assessment for hospitalization is completed by a qualified mental health professional and a psychiatrist. The initial assessment and assistance regarding hospitalization should be completed through psychology/psych associates in as timely a fashion as possible, a follow up psychiatric assessment and when indicated, assistance from psychiatry, such as “doc-to-doc.” Conversation with the hospital should also occur. Procedure 4203.04 was reviewed.

Transitions from the hospital are quite important. The ADJC has done a very good job in transitioning youth back from hospitalizations. Often transition meetings over the phone are held. These meetings are extensive reviewing what has occurred in the hospital and post hospital recommendations. Youth are seen in a timely fashion when they return from the

hospital, both from the psychiatrist and their psych associate or psychologist.

7.1 Documentation: Articles reviewed include the Third Semiannual Report dated March 15, 2005, the Second Semiannual Report dated September 15, 2005, and the Quality Assurance Review form. A variety of medical records, notes, separation log reports, the petition for hospitalization of a youth, a variety of emails, UFN projection status for Section 7, CRIPA UFN action plan transmittal forms for UFN 7.31, 7.32, 7.33, 7.3.3.1, 7.3.3.2, 7.3.3.3, 7.3.3.4, 7.3.3.5, 7.3.3.6, 7.3.3.1 through 7.3.6.9, 7.3.7, 3.1.1.8, 3.1.1.7, 3.1.2, 3.2.6, 3.2.3, 3.2.4, 3.2.5, 7.2.1.3, 4.2.4.4, 7.3.3.2, the training calendar for behavioral health services for ADJC, CV for Gary Kramer, Procedural Guidelines for administering mental health and substance use screening and assessment instruments dated January 10, 2005, a fax from Traci Wherry to Kelly Warren dated 5-20-05, Policy 4250 Counseling Suicide Prevention effective 4-6-05, Memorandum dated June 21, 2005 regarding 24-hour nursing schedules, CMS close observation assignment, incident report tracking log for CMS from 6-1-05 to 6-21-05, Assault Injury Report from May of 2005, scheduling description for the different health units and what posts are needed to be filled, Procedure 1120.07, Policy 1052,1052.01, 1052.02, 1053.03, 3025.01 and the psychiatric medication informed consent, examples of the Quality Assurance Review, review of Maintenance of Mental Health Records, emails from Mariann Picardo, MD. Interviews with Dr. Warren, Dr. Seymour, Dr. Picardo and Dr. Diebler. Personnel lists were reviewed. QA Policy 1052 was reviewed. Procedures 1052.01 and QA reports were reviewed.

UFN 7.2

a. The state shall ensure a deputy director who shall meet minimum standards as specified by the state, to oversee the mental health care and rehabilitative care of youth at the facilities.
b. The state shall provide the deputy director with sufficient staff and resources to perform the tasks required by this agreement, including:

Status: a) Substantial Compliance; b) Substantial Compliance

Discussion: Consistent with the third semiannual report, Diane Gadow, Deputy Director of the Arizona Department of Juvenile Corrections continues to oversee mental healthcare and rehabilitative youth at the facilities. Please refer to UFN 7.1 regarding the substantial compliance status in part b. Most significantly, there has been significant staff hiring, in medical and mental health.

Recommendation: Particular effort needs to be focused on hiring approved staff. There is significant concern in the number of openings, in nursing and some in mental health.

UFN 7.2.1 Oversight of mental health care in the facilities, including monitoring the performance of psychologists and private psychiatric contractors, and the development and implementations of policies and training.

Status: Partial Compliance

Discussion: The Consultants Committee spoke with Dr. Kellie Warren, Dr. Thomas Seymour and Megan McGlynn, Ed. D. QA procedures are in the process of being implemented. The specific policy and procedures regarding oversight and monitoring has not been fully written and/or implemented for psychiatry.

Recommendation:

a. Clear expectations of psychology and psychiatry need to be established.
b. Implementation of the monitoring process needs to be established.
c. Policy and Procedures regarding oversight of psychology and private, psychiatric consultants will be reviewed during the next reporting period.

UFN 7.2.2 Monitoring whether staff for resources are sufficient to provide knowledgeable mental health care and rehabilitative treatment services to the facility youth and to ensure compliance with this agreement.

Discussion: An organizational chart with clear reporting lines has been put into place. Thomas Seymour, Ph.D. is in charge of mental health services and oversees psychiatry. See UFN 7.1. The Consultants Committee was informed that Dr. Seymour will now oversee psychiatry. Policies and protocols have been implemented and the reporting supervisory lines have been made clear.

Recommendation:

1. Follow through with the lines of communication that have been established on the policy.
2. The Consultants Committee would recommend more cohesively structuring how psychiatry is going to be supervised and how the supervisor of psychiatry, whether a psychiatrist or a psychologist will take responsibility over this.

Documentation: See UFN 7.1 Documentation Section.

UFN 7.2.3 Development and implementation of a Quality Assurance Program for mental health care in coordination with the quality assurance team.

Status: Substantial Compliance

Discussion: See UFN 7.1 Section 8 Quality Assurance

UFN 7.2.3 Development and implementation of a Quality Assurance Program for mental health care in coordination with the quality assurance team.

Status: Substantial Compliance

Discussion: See UFN 7.1 Section 8 Quality Assurance

Recommendation:

1. Clear procedures regarding mental health and psychiatric quality assurance need to be followed.
2. Implementation of quality assurance for mental health needs to be consistently implemented.

UFN 7.3 Intake Screening and Assessment:

UFN 7.3.1 The Deputy Director shall continue to develop and utilize policies and screening instruments for qualified mental health professionals to conduct proper intake screenings at each facility as soon as practicable upon the youth's admission. When no such professional is on site to conduct the screening, it shall be conducted by another staff member who has received specific training in conducting such assessments. The staff member shall, as soon as is practicable, then contact a qualified mental health professional and confer. A psychiatrist or psychologist shall review and sign the mental health needs assessment.

Status: Substantial Compliance

Discussion: Pursuant to Section III.H.5 of the Memorandum of Agreement (MOA), this section of the MOA is terminated from the agreement and no longer subject to monitoring, based upon a finding of "substantial compliance" for at least 18 months.

UFN 7.3.2 The Deputy Director shall issue policies and procedures to assure appropriate action when an intake screening indicates that a youth is taking or prior to admission may have been prescribed, psychotropic medications. This shall include appropriate steps to contact the prescribing psychiatrists when necessary and referral to the facility psychiatrist for evaluation.

Status: Substantial Compliance

Discussion: Pursuant to Section III.H.5 of the Memorandum of Agreement (MOA), this section of the MOA is terminated from the agreement and no longer subject to monitoring, based upon a finding of "substantial compliance" for at least 18 months.

UFN 7.3.3 The Deputy Director shall develop and implement policies and procedures for referral of youth for mental health evaluations based on the results of a mental health and suicide risk screening or a mental health needs assessment, other referrals from staff or the conduct of the youth during the course of confinement at the facility. These procedures shall require referrals when:

UFN 7.3.3.1 A youth's mental health poses a risk of physical harm to him/herself or others if the youth has been diagnosed as mentally ill.

Status: Substantial Compliance

UFN 7.3.3.2 The youth exhibits mental health problems but does not have a current mental health diagnosis from a psychologist or psychiatrist.

Status: Substantial Compliance
UFN 7.3.3.3 The youth is determined to be taking psychotropic medication, or has taken them in the past.
Status: Substantial Compliance
UFN 7.3.3.4 The youth requires a change of medication prescribed as a result of any mental health condition.
Status: Substantial Compliance
Discussion 7.3.3.1; 7.3.3.2; 7.3.3.3; 7.3.3.4 Please refer to 7.1 Section 2, Section 3.
Recommendation: The procedures for referrals to psychiatry and mental health are formalized. The process of implementation will be assessed on the fifth semiannual report.
Documentation: Please refer to UFN 7.1 Documentation Section
UFN 7.3.4 The deputy director shall if a need for mental health treatment is indicated ensure the youth receive the treatment indicated.
Status: Substantial Compliance
Discussion: Pursuant to Section III.H.5 of the Memorandum of Agreement (MOA), this section of the MOA is terminated from the agreement and no longer subject to monitoring, based upon a finding of "substantial compliance" for at least 18 months.
UFN 7.3.5 Each youth receiving psychotropic medication or otherwise in need of mental health treatment shall have a treatment plan in accordance with professional standards of practice. The treatment plan shall be developed by a treatment team pursuant to policies developed by the deputy director, which shall include the identification of the required members of the treatment team.
Status: Substantial Compliance
Discussion: See UFN 7.1 Section 4
Recommendation: 1. MDT procedures have been revised and approved and signed by the director on 5-6-2005. There should be consistent implementation. 2. Family interventions and cultural competency with a particular focus on transition to the community will continue to be an important part of this process and will be looked at closely when assessing implementation.
Documentation: Please refer to UFN 7.1 Documentation Section.

UFN 7.3.6 The Deputy Director shall develop and implement policies and procedures for the required content of treatment plans which shall include:

7.3.6.1 That the treatment plan be individualized;

7.3.6.2 A description of any behavioral management plan or strategies to be undertaken;

7.3.6.3 A description of any counseling or psychotherapy to be provided;

7.3.6.4 A determination of whether the type or level of treatment needed can be provided in the youth's current placement;

7.3.6.5 A description of any behavioral plan or strategies to be undertaken.

7.3.6.6. Clear informed consent needs to be given both to the youth and his guardian. The specific information given and what was reviewed should be documented. If a particular handout were given, documentation regarding what handout was given and how it was explained should be recorded.

7.3.6.7 A transition plan for when the youth leaves the care of the State, which shall include providing the youth and his or her parents or guardian with information regarding mental health resources available in the youth's home community; making referrals to such services when appropriate; and providing assistance in making initial appointments with service providers.

7.3.6.8 A plan for monitoring the course of treatment and a transition plan for youth leaving the center should be implemented.

7.3.6.9 However, nothing in this Agreement shall make ADJC responsible for providing mental health services to youth no longer in the custody of the State.

Status: 7.3.6.1 Substantial Compliance; 7.3.6.2 Substantial Compliance; 7.3.6.3 Substantial Compliance; 7.3.6.4 Substantial Compliance; 7.3.6.5 Partial Compliance; 7.3.6.6 Substantial Compliance; 7.3.6.7 Substantial Compliance; 7.3.6.8 Substantial Compliance; 7.3.6.9 Substantial Compliance.

Discussion: Refer to UFN 7.1 Section 4, Section 6, Sections a and b and Section 8

Recommendation:

1. There should be ongoing development and monitoring of treatment plans.
2. Appointments must be est up before the 10-day supply of medication is gone.
3. If the psychiatrist cannot make the meetings, his recommendations need to be submitted in writing. A clear protocol regarding this should be developed.
4. Consistency with all attending MTD meetings should continue.
5. Consistent policies, procedures, and implementation of behavioral plan need to be implemented.
6. There is still no comprehensive behavioral management plan in place.

Documentation: See UFN 7.1 Documentation Section
UFN 7.3.7 The Deputy Director shall issue and implement policies and procedures for the admission of appropriate tests (including for example, blood tests, EKG's, and abnormal and involuntary movement scale test) to monitor the efficacy and any side effects of psychotropic medications in accordance with professional standards.
Status: Substantial Compliance
Discussion: See UFN 7.1 Section 6, Section A and B
Recommendation: 1. When starting a child on a psychotropic medication, particularly if their symptomatology is significant, a followup within one week and some level of communication with the psych associate during that time is recommended. 2. Clear informed consent needs to be given both to the youth and his guardian. The specific information given and what was reviewed should be documented. If a particular handout were given, documentation regarding what handout was given and how it was explained should be recorded. 3. Follow-through with this section will be reviewed closely during the fifth semiannual assessment.
Documentation: UFN7.1 Documentation Section

APPENDIX A

Unique File Numbering (UFN) Ratings

3. SUICIDE PREVENTION

3.1. Training

UFN	Rating
3.1.1	Substantial Compliance
3.1.2	Substantial Compliance

3.2 Identification/Screening

UFN	Rating
3.2.1	Substantial Compliance
3.2.2	**Substantial Compliance - Terminated**
3.2.3	**Substantial Compliance - Terminated**
3.2.4	Substantial Compliance
3.2.5	Substantial Compliance
3.2.6	**Substantial Compliance - Terminated**
3.2.7	Substantial Compliance
3.2.8	Substantial Compliance
3.2.9	Substantial Compliance

3.3 Safe Housing of Suicidal Youth

UFN	Rating
3.3.1	Substantial Compliance
3.3.2	**Substantial Compliance - Terminated**

3.4. Supervision

UFN	Rating
3.4.1	Substantial Compliance
3.4.2	Partial Compliance

3.5. Intervention

UFN	Rating
3.5.1	Substantial Compliance

3.6 Mortality Review

UFN	Rating
3.6.1	Substantial Compliance

4. JUVENILE JUSTICE

4.1 Grievance System

UFN	Rating
4.1.1	Substantial Compliance
4.1.1.1	Substantial Compliance
4.1.1.2	Substantial Compliance
4.1.1.3	Substantial Compliance
4.1.1.4	Substantial Compliance
4.1.1.5	Substantial Compliance

4.2 Protection from Harm

UFN	Rating
4.2.1	Substantial Compliance
4.2.1 A	Partial Compliance
4.2.2	Substantial Compliance
4.2.3	Substantial Compliance
4.2.4	Substantial Compliance
4.2.4.1	Substantial Compliance
4.2.4.2	Substantial Compliance
4.2.4.3	Substantial Compliance
4.2.4.4	Substantial Compliance
4.2.5	Substantial Compliance
4.2.5.1	Substantial Compliance
4.2.5.2	Substantial Compliance
4.2.6	Substantial Compliance
4.2.7	Substantial Compliance
4.2.8	Substantial Compliance

4.3 Staffing

UFN	Rating
4.3.1	Partial Compliance
4.3.2	Substantial Compliance

4.4 ADJC's Investigations and Inspections Unit and Quality Assurance Team

UFN	Rating
4.4.1	**Substantial Compliance - Terminated**
4.4.2	Substantial Compliance

4.4.3	No Rating Required
4.4.3.1	Substantial Compliance
4.4.3.2	Substantial Compliance
4.4.3.3	Substantial Compliance
4.4.3.4	Substantial Compliance
4.4.3.5	Substantial Compliance
4.4.4	Substantial Compliance
4.4.4.1	No Rating Required
4.4.4.1.1	Substantial Compliance
4.4.4.1.2	Substantial Compliance
4.4.4.1.3	Substantial Compliance
4.4.4.1.4	Substantial Compliance
4.4.4.1.5	Partial Compliance
4.4.4.1.6	Substantial Compliance
4.4.4.2	Substantial Compliance
4.4.4.3	Substantial Compliance
4.4.4.4	Partial Compliance
4.4.4.5	Substantial Compliance
4.4.4.6	Substantial Compliance
4.4.5	Substantial Compliance
4.4.6	Substantial Compliance
4.4.7	**Substantial Compliance - Terminated**
4.4.8	Substantial Compliance
4.4.9	No Rating Required
4.4.9.1	Substantial Compliance
4.4.9.2	Substantial Compliance
4.4.9.3	Substantial Compliance
4.4.9.4	Substantial Compliance
4.4.9.5	Substantial Compliance
4.4.10	Substantial Compliance
4.4.11	Substantial Compliance
4.4.12	Substantial Compliance

4.5 Disciplinary Confinement/Due Process

UFN	**Rating**
4.5.1	Partial Compliance
4.5.2	Substantial Compliance

5. SPECIAL EDUCATION

UFN	**Rating**
5.1	Substantial Compliance
5.2	Substantial Compliance
5.2.1	Substantial Compliance
5.2.2	Substantial Compliance
5.2.3	Substantial Compliance
5.3	Substantial Compliance
5.3.1	Substantial Compliance
5.3.2	Substantial Compliance
5.3.3	Substantial Compliance
5.3.4	Substantial Compliance
5.3.5	Substantial Compliance
5.3.6	Substantial Compliance
5.4	**Substantial Compliance - Terminated**
5.5	Substantial Compliance
5.6	Substantial Compliance

5.7 Individual Education Plans

UFN	**Rating**
5.7.1	Substantial Compliance
5.7.2	Substantial Compliance
5.7.3	Substantial Compliance
5.7.4	Substantial Compliance
5.7.4.1	Substantial Compliance
5.7.4.2	Substantial Compliance
5.7.5	Substantial Compliance

5.8 Section 504 Plans

UFN	**Rating**
5.8.1	Substantial Compliance

5.9 Training and Quality Assurance

UFN	**Rating**
5.9.1	**Substantial Compliance - Terminated**
5.9.2	Substantial Compliance

6. MEDICAL CARE

UFN	**Rating**
6.1 a	Substantial Compliance
6.1 b	Substantial Compliance
6.1 c	Substantial Compliance
6.2	Partial Compliance
6.3	Substantial Compliance
6.4	**Substantial Compliance - Terminated**

7. MENTAL HEALTH CARE

UFN	Rating
7.1	Partial Compliance
7.2 a	Substantial Compliance
7.2 b	Substantial Compliance
7.2.1	Partial Compliance
7.2.2	Substantial Compliance
7.2.3	Substantial Compliance

7.3 Intake Screening and Assessment

UFN	Rating
7.3.1	**Substantial Compliance - Terminated**
7.3.2	**Substantial Compliance - Terminated**
7.3.3	Substantial Compliance
7.3.3.1	Substantial Compliance
7.3.3.2	Substantial Compliance
7.3.3.3	Substantial Compliance
7.3.3.4	Substantial Compliance
7.3.4	**Substantial Compliance - Terminated**
7.3.5	Substantial Compliance
7.3.6	No Rating Required
7.3.6.1	Substantial Compliance
7.3.6.2	Substantial Compliance
7.3.6.3	Substantial Compliance
7.3.6.4	Substantial Compliance
7.3.6.5	Partial Compliance
7.3.6.6	Substantial Compliance
7.3.6.7	Substantial Compliance
7.3.6.8	Substantial Compliance
7.3.6.9	Substantial Compliance
7.3.7	Substantial Compliance